Philanthro-capitalism in Healthcare and Medical Education: An Analysis of Situation in Kerala

Thesis submitted to Jawaharlal Nehru University for award of the degree of

DOCTOR OF PHILOSOPHY

SAJID M S

CENTRE OF SOCIAL MEDICINE AND COMMUNITY HEALTH

SCHOOL OF SOCIAL SCIENCES

JAWAHARLAL NEHRU UNIVERSITY

NEW DELHI-110067, INDIA

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CENTRE FOR SOCIAL MEDICINE AND COMMUNITY HEALTH
SCHOOL OF SOCIAL SCIENCES
JAWAHARLAL NEHRU UNIVERSITY
NEW DELHI – 110067

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Declaration

The thesis entitled "**Philanthro-capitalism in Healthcare and Medical Education: An Analysis of Situation in Kerala**" is submitted for the award of the degree of Doctor of Philosophy of Jawaharlal Nehru University. This thesis has not been submitted previously for the award of any other degree of this or any other University and is my original work.

Sajid M S

I recommend this thesis to be placed before the examiners for evaluation to award the degree of Doctor of Philosophy.

Sanghmitra Acharya

28 March 2022

Prof. Sanghmitra Sheel Acharya

Supervisor

RECOMMENDATION FORM FOR EVALUATION BY THE EXAMINER/S

CERTIFICATE

This is to certify that the dissertation/thesis titled entitled **"Philanthro-capitalism in Healthcare and Medical Education: An Analysis of Situation in Kerala"** submitted by Mr **Sajid M S** in partial fulfilment of the requirements for award of degree of Ph.D of Jawaharlal Nehru University, New Delhi, has not been previously submitted in part or in full for any other degree of this university or any other university/institution.

We recommend this thesis be placed before the examiners for evaluation for the award of the degree of Ph.D.

Signature of Supervisor

Date: **28 March 2022**

Signature of Dean/Chairperson

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Chapter 1

Introduction to Philanthro-capitalism in Healthcare and Medical Education

Background of the Study

The union government imposed a nationwide lockdown due to the novel coronavirus Covid-19 pandemic in March 2020. A few days after the lockdown, the border states of Kerala have banned interstate transportation by placing excavators and heavy vehicles on the road. As a result, people from Kasaragod who relied on hospitals in Karnataka for maternity care, dialysis and other emergency care were severely affected. A pregnant woman was stopped by the Karnataka police and denied medical care due to fear. She gave birth inside the Ambulance! Nine care users died due to the blockade until April 10. Why do people from a 'model state' go to another state for critical care? Is district health service in Kasaragod not equal to other places of Kerala?

On 16 April 2019, an ambulance from the Kasaragod district of the Malabar region in Kerala rushed to Trivandrum Regional Cancer Centre (RCC) to rescue a baby suffering from congenital cardiac disease. The ambulance was supposed to cover 12 districts with the baby with the help of young volunteers. The mission was live-streamed over Facebook to avoid hurdles between the 'green channel'. It was shared more than 31.3M times and procured 855K views. The vehicle covered 400 km in five hours, with a speed of more than 75 km/h at a stretch and reached Amrita Hospital in Kochi. The initial plan to provide treatment at Trivandrum RCC had been later changed by the direct intervention of the state Health Minister who offered state-funded free treatment at Amrita through a 'Public-Private Partnership'.

The government, ambulance driver and general public won widespread appreciation. It was not the first voyage from the Northern region of Kerala to the Southern districts where the best medical institutions are available. In December 2016, a similar 'mission' was carried out in the same way and it will continue unless the fundamental problem is fixed properly. Why does this ferrying of care receivers in critical condition from North to South Kerala occur recurrently?

From a popular humanistic viewpoint, such an effort must be welcomed wholeheartedly. However, from a public health perspective, some critical questions are to be

asked. Why is this adventurous ‘shuttle’ to bridge the gap between North-South disparity still going on even after 63 years of the formation of Kerala state?

The North-South regional disparity is evident because the Northern region lacks good and accessible health facilities (Sajid, 2015; 2019). Why is the North-South disparity in Kerala, which has historical roots (Kabir & Krisnan, 1991; HDR, 2005) not resolved yet? Why do some people and specific regions of Kerala remain in backward condition? What are the factors contributing to this disparity and what are the concomitant consequences? Why has the role of the state been undermined in addressing inequality? Investigating this persistent inequality and the major factors widening the gap between different regions and people should be conducted. Even though this is not the study's main purpose, it provides a ground and insight into the problem. The study *Philanthro-capitalism in Healthcare and Medical Education An Analysis of Situation in Kerala* will address these questions and bring forth the changing philanthropic trend in the healthcare services in the country. The scenario, various centres' inequality, discrimination, and power relations are analysed in the coming sections for a better theoretical understanding.

Theories of Inequality

Providing affordable and accessible healthcare and other services to the people in the government's responsibility. However, inequality exists worldwide due to social, political and geographical reasons. Inequality prevents equal opportunity to resources which stagnate development. In India, according to the Constitution, health is the state's responsibility. The Constitution decrees health as a principal responsibility of the respective government and assigns to enhance healthcare facilities based on the need. However, the literature points out that the efforts to materialise this goal have always encountered barriers (Acharya, 2018). Social inequality, in modern times, is defined as the ‘function of disparity in the distribution of resources’. Inequality is socially unjust and is considered the systemic and potentially remedial differences in one or more aspects of health across populations disaggregated by social, economic, demographic and geographic characteristics (*ibid.*).

The research on inequality can be divided into three leading schools that are quantitative, structural and intermediate (Guidetti & Rehbein, 2014). The structural school was developed under Karl Marx. Max Weber developed the third tradition of the theory on inequality. The quantitative school of inequality has largely revolved around economic growth,

wealth and profit and focused on the relationship between inequality and growth. Adam Smith was the leading proponent of this argument. He proposed an idea through *Wealth of Nations* in 1776 that a free market can lead to economic growth, further reducing social inequality. The quantitative school in sociology contributed nominally to research on inequality in economic characteristics. However, the attempt to examine the social structure with the help of Gini's coefficient and other quantitative measures of inequality has gained attention (*ibid.*). At the same time, the quantitative aspect of inequality is criticised by different scholars (Deaton & Dreze, 2008; Sen, 1992). The literature documents that the mere economic development did not reduce inequality but widened the gap between segments of the population in India (*ibid.*). 'Kerala paradox' is the best example of social development despite the low per capita income and industrial development. It proves that the economic development constraints need not hinder the social sector development. The state has achieved this position by inter-sectoral approach (Kutty, 2000). However, the economy cannot be ignored completely but global development reports have considered income one of the indices to identify the inequality between social groups.

With the advent of the structural school, the approach to the economic analysis of social inequality changed considerably. The focus changed from the analysis of production and distribution of income to the distribution of resources (*ibid.*). Karl Marx is the founder of the structural approach. According to Marx, only some segments of society interact with the world as labour, while others reap the profits without having to perform labour. This is the basis of class divisions in society. In an industrial society, there are proletarian (workers) and bourgeoisie (owners of the resources) classes. The bourgeoisie has the capability to produce and sell goods that shape the social and political order of a society. Since the means of production is controlled by wealthy people in a society, the affairs of that society are designed by them (Banks, 2007). Karl Marx made this conflict more explicit in economic analysis by introducing the notion of surplus-value. According to Marx, profit depends on the surplus value that the bourgeoisie extracts from the workers' labour. It is defined as the value difference between output produced by workers and their wages. It is a measure of exploitation by the class of bourgeoisie or capitalists.

Talcott Parsons (1939) developed the concept of social structure as the differentiation of society into social groups. *'Social stratification refers to the differential ranking of the human individuals who compose a social system and their treatment as superior or inferior*

relative to one another in socially important respects' (Parsons, 1940 p. 841). He also established an explicit link between social structure and the division of labour without confounding the two. In India, social stratification is based on caste and religion. The higher rank in the social structure is for those in the upper ladder of the caste stratification. At the same time, the religious majority of the country enjoys the privilege (Nanda, 2009). Hence, it is reflected in the social exclusion of certain sections and results in inequality.

The quantitative tradition in economics focused on growth has not been able to explain inequality. Predictions about inequality trends from the 1990s have been proven wrong because their focus was on numbers and not on structures. The notion of development and inequality has changed drastically in the 21st century. The strata of society like caste, class, gender and religious divisions contribute to the uneven development outcome. Inequality depends on the extent to which the stratification is used for discriminating individuals or social groups in that society.

The third section of sociological research on inequality has emerged between the structural and the quantitative traditions. After Marx, Max Weber in 1921 argued that social structure was more complex than economic classes proposed by Marx (Waters et al., 2010). Many groups are neither capitalists nor workers that Marx does not realise. Weber proposed that factors apart from occupation and wealth that contribute to social discrimination should be considered. Theodor Geiger (1932) came up with a complex model of stratification. These stratification theories follow Weber in his critique of Marx and set up elaborate and complex models of social structure. They are less theoretical than Marxism and less focused on economic and historical factors (Guidetti & Rehbein, 2014).

In a stratified society, for example, the caste-based religious society of India, the power centres would evolve and powerful groups in terms of caste and religious superiority dominate the less powerful. The situation is similar in Kerala; politically, they become pressure groups and can mobilise the resources and assume it unfairly. Hence, the villages populated mostly by Dalits, Tribals, and Muslims are backward in terms of public resources.

Based on these, a single theory cannot solely explain the inequality visible in a state like Kerala. A synthesis of different theories would better explain the source of inequality. It lays on multiple reasons where control over the capital by some groups and stratification of the given society are important. As Bourdieu analysed, capital has different dimensions. The

people on the upper ladder of the social stratification take control of social, cultural and economic capitals. While they take hold of public resources, the weaker sections of the society are pushed to the fringes of development. So, we are confined to explaining social inequality in Kerala as the control of public resources (capital) by a few based on the social stratification. In which economic condition, social ranking and power relation will be analysed.

In the Indian social structure, which is based on caste and religion, inequality is interwoven with power. The discussion on inequality is incomplete without considering the power relations between social groups based on their socio-demographic characteristics. It is crucial to examine why people are discriminated against based on social and geographical identities. The discussion will lead us to the decision-making capacity of social groups or the power and authority. Historically, certain sections of society have been thrown out of the corridors of power and hence they are unable to channelise the development to the regions where they live. Dalit and Muslim communities, in terms of power, have been undergoing systemic discrimination and the source of opportunity to get into the discussions of 'decide or not to decide' become frail. So here is a historical analysis of power to understand the context of Kerala where it is exercised.

Historical Analysis of Power

This section deals with the theories of power, which helps analyse the changing conceptions of power over time.

What is power? Philosophers and thinkers have raised this question for many years, which gave birth to many definitions of power. Modern thinking on power was first seen in *The Prince,* work by Nicollo Machiavelli (1465-1527). Machiavelli, an Italian political theorist, is considered the precursor of the discipline of political science. *The Prince* is a political treatise written in 1513 and first published in 1532. He wrote this piece after his forceful exile from Florence and tried to advise the prince of Florence to hold on to power through his work. Machiavelli represents strategic and decentralised thinking about power and organisation. Machiavelli and his successors may have interpreted what power does. They perceive that power is a desirable end. In contrast to others, he had written the strategies of power rather than serving or fixing the power (Clegg, 1989).

On the contrary, Thomas Hobbes (1588-1679), an English philosopher, had different views on power. His masterpiece *Leviathan,* written during the English Civil War and

published in 1651, deals with the structure of society and a legitimate government. He thinks that power is hegemony and is centralised and focused on sovereignty. He says that there is a total political community, the embodiment of which is a state or a community or a society. He continues that the power develops from a single unit of society or community and is ordered according to uniform principle. Power possesses a continuity of time and place (Sadan, 1997; Clegg, 1989).

Alexis de Tocqueville (1805-1859) was another French philosopher who had dealt with aristocracy and power. 'Some questions raised by Tocqueville in his work, *Democracy in* America is helpful to understand modern philanthropy and their power relations (McGoey & Thiel, 2018). In the chapter named *How an aristocracy may be created by industry*, he discusses employment. He says that when work becomes more complex or specialised, the employees become weaker and then they will be more dependent on the employer. It creates a super-rich called 'business aristocracy' (McGoey & Thiel, 2018; Sadan, 1997). He had termed aristocracy because there are two classes obedient and commanders. The obedient are in a state of constant dependence on the others as they are the commanders. In addition, English and French aristocracy whose power is rooted in control over land ownership. However, he predicts that the rapid rise of industrialisation will generate an unprecedented type of social order. He advocated for landlords and industrial aristocrats from the United States, France and England to reinvent feudal notions of duty towards the less privileged (McGoey & Thiel, 2018).

Robert Dahl, a contemporary political scientist (1915-2014), defines power as similar to Weber's approach. At the same time, Dahl locates the power in the boundaries of a community which is different from Webers' organisational approach. His major contribution is in the development of ruling elites which had come forward after World War II. According to Dahl, 'power is an ability exercised in a community by individuals over others while they are prevented from performing what they prefer to do'. One can get somebody to do something that would not have been otherwise done. Dahl's famous work published in 1961, *Who Governs? Democracy and Power in an American City* analyse the power dynamics in Haven. In contrast to C W Mills, Dahl argues that power in the US is pluralistic. It is distributed unequally among different groups in constant competition with each other. However, Luke (1974), Peter and Morton (1962) argued that Dahl had failed to understand the different dimensions of power (Lukes, 1974).

Steven Lukes, a British political theorist, developed a three dimensional model of power in his book, *Power A Radical View* in 1974. His contribution was chiefly towards the ongoing discussion on power among social and political scientists during the time. He addressed questions on power through his book like 'how to think about power theoretically' and 'how to study it empirically'. He says that power should be understood in three dimensions rather than conventional one or two-dimensional aspects (*ibid.*). Peter Bachrach and Morton Baratz (1962) put forward a model of two-dimensional power such as the 'overt dimension' and 'covert dimension' of power. Luke added one more dimension to this; latent dimension. The overt dimension deals with the declared political preferences as they reveal themselves in open political play.

On the other hand covert dimension of power means political preferences that reveal themselves through complaints about political non-issues. The 'latent' dimension of power deals with relations between political preferences and real interests. Luke brings the notion of 'interest' in the power dimension. (Lukes, 1974; Sadan, 1997).

One of the giants who contributed to understanding power is Michel Foucault (1926-1984), whose work is transdisciplinary, ranging from sociology to psychology and philosophy. Foucault extended the discussion of the concept of power from sociology to all other fields of social sciences. Foucault believed that there is no source from which actions are derived but an infinite series of practices. He introduced a decentralised position of power. Power relations are influenced by culture, time and space. Hence, he deals with Western society in contemporary times. He says that power is neither a commodity nor a position or a prize. Instead, it activates political technologies and is concomitant with the social body. As the general belief of power is not limited to political institutions, Foucault predicted that power is at its peak when situated inside specific institutions such as hospitals and jails. He put forward a positive aspect of power termed 'productive power' (Faubion, 2000).

Max Weber's (1864-1920) definition of power is the most widely accepted. He defined power as 'the likelihood that one person in a social relationship will be able to carry out his own will despite resistance' (Kalberg, 2005). Weber's approach to power is connected with bureaucracy and linked with the concepts of authority and rule. Weber identifies power as a factor of domination based on authoritarian interest. He analysed the source of authority that legitimates power. Three sources of legitimation are there; charismatic, traditional, and rational-legal (Sadan, 1997).

Weber distinguished power from authority. For him, authority refers to 'the likelihood that demarcated command will find obedience among a specific circle of persons'. A definable group of individuals will orient their social actions to giving commands due to various motives, and another definable group will orient their social action to obedience. Furthermore, those commands are empirically carried out. In general, the foundation of every authority is a belief of whichever persons are exercising authority (Kalberg, 2005).

Thus, participating in the power to decide or not to decide is equally important in the process of reducing inequality. Social groups which are expelled from power due to the structural reasons of society face discrimination based on their social identities. The government and bureaucracy are miniature of society. They have been formed from the same social structure and hence the inequality persists. Hence, equal opportunity to all the resources and share in the power structures would reduce inequality. Here power and inequality theories are used to understand the philanthro-capitalists institutions, which are developed out of the unequal distribution of resources across regions in Kerala. Due to the shortage of good and accessible health facilities in different parts of the state, philanthropic institutions emerged as a resort to many and occupied the space (Sajid, 2015). The sections following will deal with the historical developments of charity, philanthropy and philanthro-capitalism.

Roots of Philanthropy and Changes over the Period

In most societies, religion shapes the value system, including individual giving and supporting the destitute. Philanthropy emerged from religious motives either as individual giving or in an organised way. It varies with religion, region and culture. Anthropologists argue that the history of charity dates back to primitive societies (Shultz, 2009). In the primitive age, humans had lent helping hands to the family members first, then to clan members and later it extended to the tribe and needy in their villages.

> *"Among primates, the gift of grooming is the simplest and most vivid example of these behaviours of reciprocity. Mutual grooming serves to connect individuals and to enhance the quality of life for the group as a whole; so too do reciprocal acts of benevolence."*
>
> (Shultz, 2009 p. 2)

When institutionalisation took place, the power shifted to clergypersons and religious centres. Individuals began to give charity through mediators such as church and clergypersons. Cohen says the evolution of power structures had expanded the scope of charity. However, individuals maintain their giving by expecting *"redemption and a place in heaven"* (Cohen cited in Shultz, 2009 p. 3). When humans became wealthier and advanced in science and industry, a systematic and scientific way of philanthropy through specific projects developed specific tasks and impacts (*ibid.*).

Religion-based philanthropic initiatives were predominant up to the 16th century in Europe. Islam in the East preaches alms as a right of the poor rather than the giver's generosity. Two kinds of giving are promoted in Islam. One is '*Sadaqa',* which is not compulsory and the individual can decide upon it, but it is promoted and highly rewarded. Another one is '*Zakat'*. Every individual shall be liable to donate 2.5 per cent of their annual savings to the Islamic State or any collective effort in the absence of the state. In early Hebrew history, one-tenth of an individual's income was given as charity, donated to the church, which is called *Tithe*. They considered this as a religious duty. Teachings of Confucius in China and Buddha from India promoted almsgiving. Hindu religion has an idea of '*Daan*' for giving. 'Upper caste' and wealthier people practice this by giving any offering as money or material to the priest named '*Sadhu*' who is ascetic to material life (Nundy, 2009). Most religions have defined the ones who are deserving of receiving and the ones who are obliged to give.

Philanthropy during Industrial Revolution and Economic Liberalisation

The industrial revolution made rich people better off. As a result, they contributed or started guild hospitals for the welfare of the poor. The Revolution also brought new medical knowledge and technological advancement in treatment which completely transformed the medical practice (*ibid.*). Marco describes the reason behind the practice of charity by wealthy European individuals. There was some *'collective good'* (Van Leeuwen, 1994) behind European charity. He says that charity helps to keep poor people in their miserable condition. During industrialisation, the market needed a massive labour force at a cheap expense. Paupers were a cheap labour force; hence some had to be paupers to sustain market production upward. At the same time, these paupers were considered 'public nuisance' who indulged in crimes. Hence giving charity to these paupers would reduce crimes like theft and robbery. Homeless and paupers were prone to deadly diseases, which would again be a social threat. The wealthy people were afraid of being infected, thus giving charity to help the poor maintain the wealthy's

better living conditions and reduce the risk. Some wealthy believers considered giving charity a sign of social honour and status. In England, this kind of belief was seen during the revolution (*ibid.*).

The period of the post-industrial revolution saw the transformation of charity into philanthropy. Economic liberalisation was a driving force in the emergence of a new middle class and the accumulation of substantial private wealth linked them to the global economy (Nundy, 2009; Shultz, 2009). New industries such as information and telecommunication grew fast and made a considerable profit (Foundation Centre, 2014). The economic change was also accompanied by inequality and the concentration of wealth in the hands of a few. The government is shamble and impotent in addressing the growing inequality. There was also an explosion in civil society organisations fighting social problems. Hence the external forces found an opportunity to intervene in the issue (*ibid.*). Corporate and business ventures started investing in philanthropy. Now philanthropy itself has become a business venture with many facets at international and regional levels. The typology of institutions has been widened based on nature and intervention. It crossed beyond the geographical limit during the 19th century, and globalisation made the market is more open, which paved the way for international philanthro-capitalism.

Philanthro-capitalism: the new form of giving

Philanthro-capitalism is a combination of two terms philanthropy and capitalism. However, both are two different philosophies and applications. It simply means that capitalism is for human development. Capitalism is an economic idea that propagates a free market and the accumulation of infinite private wealth. Philanthro-capitalism emerged as a new form of charity, which uses business techniques, tools and market forces for eliminating social problems. It traversed the geographical boundaries and even reached the muddy houses of Indian villagers as a family planning programme and malaria nets. In 2010, forty American billionaires had pledged to give half of their wealth in their lifetime for human wellbeing. It was inscribed as 'giving pledge'. (They were named after *"good club"* by Mathew Bishop, a proponent of philanthro-capitalism) at the Global level (Rogers, 2011). The term has been quoted in different ways like 'venture philanthropy', 'social entrepreneurship' and 'impact investment'.

The advocates of philanthro-capitalism propose market solutions, business principles and profit incentives that create sustainable and innovative solutions for the world's most pressing social problems. In an interview, former American president and the chairman of the 'Clinton Foundation' Bill Clinton says, "repurpose business methods and business culture to solve the world's problems and reinvent philanthropy" (Rauch, 2007). They do not simply donate grants and aid to support global health but 'seek to harness the market's power' to produce the financial outcome. They foresee investments as a probable economic return and assess the performance and outcome using business metrics (Aneja, 2016). The then advisor to the United Nations Secretary-General Jeffrey Sachs states that 'philanthro-capitalists can make Africa a poverty-free continent that all G8 nations cannot do even if they come together' (Boulton and Lamont, 2007 cited in Edwards, 2008). It is clear that philanthropy, business and profit-making are suggested to alleviate social problems where the government has no role except opening the ways for their market. Oracle founder Ellison says a step ahead of that the 'profit motive can give solutions to the social problems more effectively than any government or private philanthropy'. All these leading philanthro-capitalists believe that giving foods for the poor or vaccination against an infectious disease would resolve all problems in society. They deliberately forget that every social issue has deep-rooted structural links that they cannot address. The world's most pressing social problems can be solved only through an inter-sectoral approach which ranges from the culture of a community to the power relations to historical underpinnings of that problem. The scholars from different sectors point out that the philanthro-capitalists promote vertical solutions based on technologies and solutions for each issue and lack a holistic approach (Edward, 2008; Jenkins, 2011; McGoey, 2012; Aneja, 2016). The vertical approach is not helpful to strengthen the health system in poor income countries.

It is more alarming that these organisations do not have 'sufficient accountability' (Clark and McGoey, 2016). They simultaneously set up Limited Liability Companies (LLC) which is neither charitable trusts nor private foundations. So, they need not be accountable to the public about their pledge and donors can invest in LLCs for-profit augmentation. More dangerous is that this profit can be used for personal causes, lobbying and political campaigns (*ibid.*). A study published in The Lancet provides some other insights into this problem. It reveals that only a tiny proportion of the grants assigned to the health sector have been spent to the Global South (McGoey et al., 2009). A report says that the public will never know whether the contributions are spent to the promised area or not (McGoey, 2016). Another study by Global Justice found that BMGF invests in chemical and pharmaceutical companies

including Dow Chemical, Glaxo Smith Kline and Pfizer and is making a profit out of this (Curtis, 2016).

Most of the philanthro-capitalists foundations are driven by the interest of a particular family or a minimal number of individuals, reflecting the lack of accountability. Facebook founder Mark Zuckerberg and Priscilla Chan own a charity foundation. The Rockefeller family managed one of the biggest foundations in the 20th century. Bill Gates and Melinda Gates owns BMGF, Ford Foundation by Henry Ford and Clinton Foundation managed by the Clinton family. Global Health Watch criticised the undemocratic intervention of philanthro-capitalist foundations in the setting up of global health policy. The report says that the foundations lack public accountability and become dominant actors in policymaking bodies (Global Health Watch, 2009).

At the same time, their growing dominance and influence over governments and other international bodies like World Health Organization (WHO) are questioned by many scholars (McNeil, 2008; Jenkins, 2011; Rogers, 2011; McGoey, 2012). The dominance, without doubt, will create an adverse effect on Global and regional health and allied government policies. Bill and Melinda Gates Foundation (BMGF) contribute up to ten per cent of their annual budget to WHO and sometimes it exceeds than the contribution of all member states (Clark and McGoey, 2016). BMGF has outlaid a $32.9 billion grant in aid for global health, while WHO's budget for the health programmes was $4 billion (Aneja, 2016). The engagement of big foundations in health care activities creates hurdles to access life-saving drugs due to high-price in the market because of the patent and intellectual property rights demanded by the big philanthro-capitalists foundations (*ibid.*). India has amended compulsory licence policy after the continuous pressure from the United States and European Union and opened the market to big pharma companies to produce life-saving medicines (*ibid.*).

'*Philanthro-capitalism in Healthcare and Medical Education: An Analysis of Situation in Kerala*' is a study on the features of philanthro-capitalism related to religion and caste-based philanthropic institutions in the state. Religious and caste groups run hospitals and medical colleges under trusts registered as charity organisations. Trusts are non-profit entities in legal as well as moral aspects. However, the lack of transparency, democracy and social justice in these institutions should be analytically studied. The study examines interference of religion, caste, the exercise of power and authority of such institutions on government and the people interacting with them. The institutions termed as that of philanthro-capitalist ones and yet act

like private centres concentrating only on profit augmentation is also a central point of the study.

The philanthropic institutions in Kerala are rooted in religion and caste-based charity. They claim that the institutions stand for service and social justice. However, a primary analysis proved that (Sajid, 2015) they serve the creamy-layer of the society and have accumulated massive capital over the period. It is one of the fundamental traits of any philanthro-capitalist's organisation. Whether it is working at the international, national, or regional level is not a matter of profit augmentation.

The philanthro-capitalists are, internationally speaking, powerful and influencing the states. However, in the context of Kerala, these organisations are more powerful at the regional level when the attributes of caste and religion intersect. The organisations using the identity of religion and caste for philanthropy has been termed in different ways in former studies. There are charity organisations that work sincerely without seeking profits, but this study uses the term 'philanthro-capitalists' to represent organisations oriented towards profit. Hence, the study uses 'philanthro-capitalism' to explain the religion and caste-based, profit-oriented institutions working in Kerala's healthcare and education sectors.

The Problem of Philanthro-capitalism in India and Kerala

Indian philanthropy has religious and caste links where charity organisations are legally registered as trusts. They are small entities in terms of assets and wealth compared to the international foundations and provide education and healthcare services. Organisations based on religious and caste motives manage the trusts and charity institutions. Organised philanthropy in India has transformed into profit-oriented giving along with the global changes that occurred in the healthcare and education sectors (Nundy, 2009). However, many Indian philanthropists who took part in the 'Giving Pledge' disseminated by the 'Super Wealthy'. Bill and Melinda Gates met with Mukesh Ambani, Ratan Tata, and Lakshmi Mittal, India's 'richest men'. They agreed to contribute to the philanthropic causes driven by 'Good Club' (Ramdas, 2011).

India is a fast-growing economy in the world. Many Indian industrialists are ranked in the Forbes magazine's billionaires list despite India being ranked highest in the World Hunger Index and performing worst in nutritional status. India had 121 billionaires in 2017-18, raised from 102 in 2016-17. In 2018-19, there were 831 wealthiest persons in India. Out of these, 39

persons, including one and only one woman, donated more than 100 million rupees for philanthropic activity. The top-ranked richest person Mukesh Ambani has a net worth of 371,000 crores in 2019 donated 437 crores for education, health and rural development. The number of billionaires in India increased from nine in 2004 to 40 in 2007. The Indian billionaires' growth rate was more than twice the billionaires in the United States (Forbes, 2017; ET, 2018).

The wealth of 101 richest people was more than the union government's budget in the financial year of 2017-18 (Shetty, 2019). On the other hand, India was ranked at 131st position in Global Human Development Index with a value of 0.628 in 2015 (HDR, 2016). While the number of billionaires and their wealth increased every year, the total donation volume declined considerably (Table-1.1). In 2013, 31 billionaires donated 15,250 crores, with an average size of 492 crores per one billionaire. When the number of billionaires increased to 39 in 2018, the total size of the donation and average size also declined (Table-1.1).

Table-1. 1 Number of Richest Persons and Their Contribution from 2013-2018 in India

Year	Number of persons donate >10 crores	Total amount (in crores INR)	Average size of donation in crores
2013	31	15,250	492
2014	50	15,000	300
2015	36	32,400	900
2016	27	2,334	86
2018	39	1,560	40

Source: Hurun India Philanthropy List cited in Shetty, 2019
Note: The metrics changed from 2017 and hence the data is not available

The Bain & Company report on Indian philanthropy (2015) notes that foreign philanthropic funding in India has doubled. However, the economic boom has created huge wealth accumulation among wealthy Indians, but the benefit of growth has not reached the 1.2 billion poor in the country. The rich fortunate has also agreed to this condition and they wrote it to the Supreme Court Judges and formal governors of central banks. In an open letter, they wrote that the benefits of growth are not reaching the poor and marginalised sections

adequately due to impediments to economic development (Beckett, 2011). In 2005, one million households earned $34,000 annually, but the number of households had risen to 2.5 million in 2010. Contrary to this, the number of households that earned less than $3,000 annually had risen from 101 million to 111 million (Beckett, 2011, Ramdas, 2011; Shetty, 2019).

As part of the neo-liberal policies, the government welcomes private capital in the social sector and grants public assets and money to these industrialists turned philanthro-capitalists. Along with this, an under-reported or sometimes legitimised religion-based philanthropy headed by saints and self-styled god-men (very rarely god-woman) has mushroomed in India, especially in the last two decades. Religion or caste-based philanthropists have benefitted from the government over time. There are plenty of examples that the government granted public property to the saints and their organisations. These organisations are involved in education, healthcare, research activities, and some relief work. Even after a number of social issues are prevalent in India, why they are interested and invested in health and education is an important question to be asked. Apart from that, patented spiritual training and revitalised traditional religious practices are the most celebrated selling goods of these 'philanthropists'.

Patanjali Yogpeeth is a trust registered in 2006 and a yoga guru Baba Ramdev is considered the brand ambassador of the Trust. Technically, he does not have a position in the Trust other than the ambassador because he pledged to lead an ascetic life, called '*sanyasi'* for the rest of his life, a pledge similar to the 'giving pledge' of philanthro-capitalists. He was offered public land in the state of Uttarakhand to construct their Ayurvedic hospital and research centre. The Haryana government also recognised an education system in the gurukul model by the Baba (Nanda, 2009). The RTI activists exposed that the Maharashtra government allotted acres of land to the trust at a discount of 75 per cent from the market value in 2017 (Online ToI, 2017). The Uttar Pradesh government sanctioned to provide public land at a subsidised rate to Baba to construct a 6000 crores mega food park in Greater Noida (Online ET, 2018). The trust focuses on developing traditional herbs and cosmetic products sold by associates with Hindu mythology. On the other hand, the assets of the venture augmented ten-fold within four years and it was estimated that currently, it has assets of $758 million which shot up from $11 million in 2012 March (Forbes, 2018).

Art of Living (AOL) claims it is a *"non-profit educational humanitarian organisation"* founded by spiritual leader Ravi Shankar in 1981. It has constructed a headquarters in

Karnataka on land leased for 99 years! The Orissa government has granted 200 acres of land to build his university (Nanda, 2009). AOL is accused of several land encroachment cases also. In Karnataka, the organisation has encroached two acres of land worth ten crores of Indian rupees, which was later taken back by the Revenue authorities of Karnataka (News Minute, 2015). The National Green Tribunal (NGT) has ordered the organisation to pay 5 Crore Indian rupees as compensation for allegedly damaging the Yamuna's biodiversity during a mega event organised by Ravi (NGT, 2017).

Similar stories are ubiquitous in the Indian public domain. The government is favourable to their market interest whether it is Maharishi Mahesh Yogi of Madhya Pradesh, Putparti's Sai Baba or Pagla Baba in Uttar Pradesh. The religion-charity connection is a safe zone to these saints and god-men and their power in government makes the business easy for them. They expand their 'philanthropic' business empire through these public assets and public money.

Kerala Experience

Once hailed and praised worldwide as a replicable model, the Kerala Model of Development is now showing a negative trend (Oommen, 2017). A major concern is that private institutions dominate the healthcare sector of Kerala (Kutty, 2000; Dilip, 2008). Experts warn that the public health of the state is in a crisis (Soman, 2007). The missing out of vulnerable sections like Dalit and tribal groups has been criticised for a long (Devika, 2010; Thresia, 2014). The important contributors to the earlier developments, such as the universalisation of public education and the availability of public healthcare centres even in rural areas, are apprehended by private institutions (Dilip, 2008).

Private institutions and philanthro-capitalist foundations have taken over the place of public education centres and hospitals. The rising outcry on the deterioration of students in public schools and unfilled posts of doctors or caregivers in health centres has amplified in the last two decades (Jacob, 2014). The medical education fee is fully jostled by the philanthropic and religious institutions in the field. The current fee structure is decided jointly by the government and the management of colleges is 26 times higher than the last year's fees (Online ToI, 2016; Online Manorama, 2016). As a result, equal opportunity for vulnerable sections to enter the medical field is a far-away dream. On the other hand, the increasing cost of care in

Kerala is also alarming and is pointed out by many concerned centres (KSSP, 2005 cited in Maya, 2013).

One important malingerer of this melodrama is philanthropic foundations that have undergone socio-political transformation linked to global changes. Their increasing upper hand over the government will worsen the situation. The religion and caste-based philanthropic foundations augment their profit in the guise of philanthropy and compete with the private sector. The philanthro-capitalism at the international level is a new face of capitalism with the same old idea. Their basic argument is that business methods in philanthropy is the best solution for social problems and making a huge profit out of it. The proposed study examines the features of philanthro-capitalism and compares it with profit-oriented philanthropic foundations in Kerala. Similarly, the analysis of their development based on Weberian theory on power and authority will give insight into the state-philanthropic nexus and its possible consequences in social development.

Conceptual Framework

Charity was a part of the civilised life of human beings even in the pre-industrial society. The foundation of charity is laid on religious motives which promote helping each other. It is a value based on altruism and considering fellow beings is a quality of civilised society. Religious institutions were the centre of charity activity by providing food or money to poor people. The religious charity was geographically bounded in a limited population. However, it was less organised and volunteer giving was dominant, yet the roots are the same. Religious institutions managed alms-house, asylums and orphanages whose inmates were very vulnerable people. Since the charity was a selfless individual motive, it did not address the roots of inequality and hence it did not envision a social change.

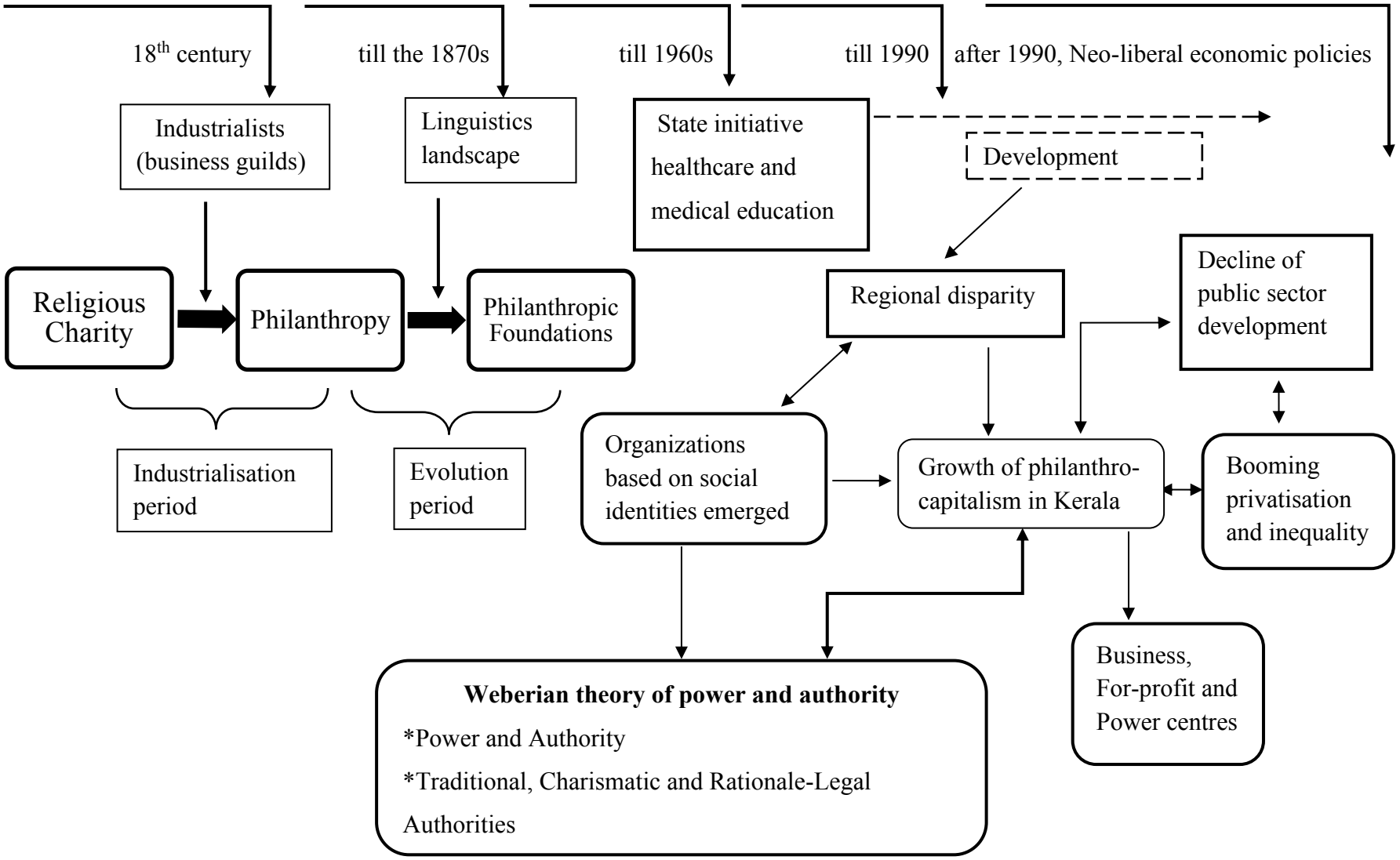
During industrialisation, business guilds were formed and contributed to the welfare of the poor and the labour force. The term charity was also changed to philanthropy (Figure-1.1). It is more organised and secular by being dissociating from religious centres. Unlike charity, philanthropy has both motive and goal. It aimed at the industrial output, more production and profit. Philanthropy is more focused and result-oriented than charity. It later contributed to developing organisations with various objectives that aim welfare of the people living in vulnerable conditions. The industrial period witnessed an evolution in philanthropic

organising; bigger foundations, corporate organisations, NGOs and social enterprises are some of them. Each of these has specific goals and aims among the targeted population.

In the latter part of the 19th century and early 20th century, community organisations based on social identities emerged in different parts of pre-modern Kerala with specific political and social goals (Figure-1.1). People from oppressed castes and backward religious groups formed these organisations strived for equal opportunity and civic rights. Inequality and social injustice led to the formation of these civic organisations. The major thrust was empowering the respective community by providing education and public awareness to its members. It is unfair to categorise these activities as a charity because they largely concentrated on socio-political rights and equal status in society. However, these organisations can be viewed in history as predecessors of philanthropic organisations.

Kerala state was formed in 1956 after federalising three distinctive geographical locations into one state based on a common language. The three parts were at various development grades and steadily evolving to a new model of social development. The geographical disparity between the two regions of the state is an unsung saga of 'Kerala model development', which is still persistent. The state's northern region also called Malabar, comprises six districts is relatively deficient in public health infrastructure and health resources. The former civic organisations and contributions of the gulf migrants concentrated on the infrastructure development of the Malabar region. It steadily increased from the 70s and witnessed a boom during the 90s (Figure-1.1). During the same period, government spending on health and education considerably declined.

Figure-1. 1 Conceptual Framework of Study



The profit-oriented philanthropy gained momentum after 1990; the year was a juncture of socio-economic changes. During the 70s, the state of Kerala witnessed a fiscal crisis and economic recession at the global level that pushed nations to move towards new economic policies by reducing social sector expenditure. A new era of neo-liberalisation was born globally and India opened the market to private sectors to invest in education and health. As a result, global philanthro-capitalist foundations engendered cross border investments (Figure-1.1). The literature points out that wherever the philanthro-capitalism enters, the public sector gets weak (McGoey, 2012), or the public sector is shambled, they succeed there.

McGoey points out that the Gates Foundation weakening the US public education is the best example of this. Gates Foundation proposed Common Core State Standards (CCSS) at the school level across the United States to improve the standard of high school students. It aimed at math and language testing in American schools and they gradually advanced to a digital education model using Windows-8 supported touch screens. By adopting this model, all school testing will be changed to computer-based tests and schools will be forced to rely on Windows-based computers. Hence, ultimately, Microsoft made a huge profit out of this (Mott and Sirota, 2014). For this, they flowed money to the American Teachers Association, National Education Association, the US Chamber of Commerce and all political groups (Layton, 2014). The Foundation has also financed studies that demand comprehensive changes in the United States' college education. BMGF funded more than three organisations to shape studies and influence States' education policy (Mangan, 2013).

The government of Kerala slashes the budget from education and health (Kutty, 2000). The gap is filled by the private sector and international donor organisations that provide funds in their focused area. Once they withdraw the funding, the citizens will be sacked and the private sector will take advantage, as witnessed in the US (Sampath, 2015). Hence, it needs to be studied whether the philanthropic institutions are eroding the public sector development in health care and the private sector is making advantages from philanthropy in Kerala.

Linsey McGoey (2012) and Robin Rogers (2011) explain that philanthro-capitalists influence public policy for their market interest. Roger says philanthro-capitalists - the policymaking powers- and philanthro-capitalism are related to each other but not identical. She went on to say that 'Philanthro-policymaking' powers and rich shape the policies in the states. One of the major accusations against them is that they lack transparency and accountability (Global Health Watch, 2009; McGoey, 2012; Clark and McGoey, 2016). So, in Kerala, it

should be studied whether philanthro-capitalists influence the government in favour of them in the health care and medical education sectors. Weber's theory of religion and authority is helpful to understand the phenomenon in Kerala.

Contextualising Philanthro-capitalism

The philosophy and character of philanthropy vary from place to place and time to time. The practice of philanthropy and investment of the Saudi Arabian Prince Alwaleed Bin Talal and Robert Bosch in Germany will vary based on their region, politics and belief. Alwaleed invests his capital in electrifying remote villages building orphanages and schools, while it does not appropriate to Bosch. In the case of assets, Hong Kong-based entrepreneur Li Ka Shing has an asset of eight billion, which is only one-sixth of Bill & Melinda Gates and their annual spending reaches close to half of Shing's total endowment (Martens & Seitz, 2015). Both of their capital and so as the influence is different in the global community. It is understood that the culture, religious values, political history and economic strength of a region or group or individual shapes philanthropic activities. Hence, philanthropic organisations and their influence have to be analysed by considering the regional factors which shape them. In a globalised world where charity stands for profit, philanthro-capitalism could not be defined by considering their assets, capital, or power. However, they can be compared by using similarities they share mutually. Beyond all these diversities, the major commonality is spending wealth for augmenting profit in the name of philanthropy.

Philanthropy had swept religious charity out long back and now capitalism seized it fully. Capitalism is related to the very roots of accumulation of wealth, market and product or means of production. In a capitalist economy, every individual does not get access to healthcare and education unless they have any kind of capital (either social or cultural or financial). If the social characteristics of the beneficiaries in a philanthropic healthcare institution are analysed, it will be found that they have a sort of capital backup. A former study (Sajid, 2015) reveals that those who do not have capital cannot approach these institutions for healthcare. At the same time, middle and upper-class users of these institutions prey on out-of-pocket expenditure in return for healthcare services. It is questionable whether the religious and caste-based charity in the health sector of Kerala has adopted business techniques and act as private institutions. Since the term Philanthro-capitalism is fit for or has been used for giant donors of the world, the philanthropic institutions in Kerala have similar features. It is distinguishable by divorcing the term philanthropy and capitalism. However, further study is needed on philanthropic

institutions in Kerala and philanthro-capitalism to frame a valid argument. As mentioned earlier, the features of philanthro-capitalism vary from place to place. Hence how the caste and religion particular to the context of Kerala are related to global philanthro-capitalism must be investigated.

Healthcare service is a public good that should be accessible to all. As Bishop (2006) says in his book titled *'How the Rich can Save the World',* here the 'rich' deliberately side-lines the responsibility of government to provide services it ignores and the role of civil society (Sampath, 2015). Every citizen has a right to government-funded services. However, due to the decline of the state's role, these organisations invest in the social sector. When the government fails to render the services, the private sector will seize the ground. The philanthropic institutions in Kerala progressed parallel to private health care lack of public institutions was one of the causes for this negative trend.

Philanthropy is widely used in the thesis to denote modern charity. Philanthropic foundations or organisations are modern organisations that consider charity is a major area of interest. Hence these terms are interchangeably used in this study to represent organisations that provide healthcare and medical education services as a charity entity. Charity is meant for unorganised aids and services, while philanthropy is a comparatively new term interlinked with capitalism and profit motive.

Weber's Theory on Power and Authority: A Theoretical Frame of the Study

Max Weber's work 'Economy and Society' (1921) conceptualises the exercise of power and authority to influence or control those who do not have it. By power, Weber says that 'the chance of individual or group to enforce their will in a social action even against the resistance of others involved in the action' (Weber, 1921). When viewed sociologically, the concept of power is all conceivable qualities of a person. All conceivable gatherings can place a person in a position where s/he will carry out their will. Weber says that power is involved in social organisations, termed *'Party'*. Parties are social groups that tend to control organisation and administration. This tendency ultimately ends at an ideal or material advantage (Allan, 2005). In other words, parties are organised groups in the society oriented towards the possession of power and they attempt systematically to reach the goal (Kalberg, 2005).

Religion and caste-based philanthropic institutions are, for example, *'Party'* or organised groups in Kerala that stand for specific goals. A traditional society like India, where

religious and caste identities are honoured or dishonoured, offer them more space to get powerful. Their power is not only "economically conditioned," but it is also determined by social honour, prestige and reputation (Weber, 1921; Kalberg, 2005). The holding of power is not functional until the people legitimise it. Once power has been legitimised, it will become the authority (Allan, 2005). Legitimisation is a process to institutionalise the power, moreover giving a moral base to it. Legitimisation makes a social structure valid and acceptable. For Weber, cultural legitimisation and authority are vital components of social change (*ibid.*). That is, authority and legitimisation are the factors of socio-political change that occurred to philanthropic institutions in Kerala.

In addition to this, Weber's theory on Traditional, Rational-Legal and Charismatic authorities are helpful to understand the growth and influence of philanthro-capitalist forces in Kerala. The traditional authority is based on faith in the sanctity of religion used by the organised groups of religion and caste-based philanthropic institutions. At the same time, charismatic authority is a belief in the intrinsic ability of an individual through the routinisation of charisma (Hamilton, 2002). Authority is *"a definable group of individuals will orient their social action to giving directives or commands that another definable group will orient to obedience"* (Kalberg, 2005 p: 174).

Weber uses the term 'charisma' to refer to power which is extraordinary qualities possessed by people. Charisma may be inherent, or it may be acquired by an individual. Charisma is acquired only through rigorous ascetic practices, which are odd or by undergoing some extraordinary experience. It may be acquired through spending long hours in mystical contemplation or through strange mental states such as trance or possessions by spirits (*ibid.*) as it is the same as 'magic'. The magic is not removed from post-industrialised societies. It is unclear whether charisma refers to particular people who are 'extraordinary' or refers to the situation. Both person and situation are intertwined in a combination, thus making charismatic leadership. However, "charismatic transformation" (As Weber says institutionalisation of charisma) with a group of followers is a must happen to form a leader. The idea of charisma in a person needs social and political recognition (McCulloch, 2014). As a broader understanding, 'men are the leaders' and only a small 'negligible' number of charismatic leaders are females. If they want to compete with the male, they have to acquire certain conventional masculine characteristics and cast off some feminine traits during their transformation (Kalberg, 2005; McCulloch, 2014). For instance, Amritanantamayi in Kerala claims that to manifest 'Krisna',

a male god in Hindu belief, she 'discarded the state of menstruation' to become 'pure' (Najeeb, 2014). Since charisma is referred to as power, it can also be attributed to the organisation or group of individuals. The theory of authority and charisma provides a framework to analyse the philanthro-capitalist institutions backed by god-men and women in Kerala.

Charismatic personalities derive a 'right to rule' from their extraordinary personal qualities and the belief of the ruled in their superhuman inspirations. Traditional rulership like patriarchal, feudal and priesthood rests on an established belief in the sanctity of old traditions and the legitimacy of those exercising authority under them. Rational-legal or bureaucratic authority is endowed with legitimacy by believing that rules, regulations, statutes, and laws have been appropriately enacted through the objective modes of procedure. In other words, it rests on a belief in the legality of such enacted rules and the right of those elevated to authoritative positions under such rules to issue directives. Bureaucratic authority becomes all-pervasive in modern societies and stands in radical opposition to charismatic and traditional authorities.

Charisma can be understood to refer to an extraordinary quality of a person regardless of whether this quality is actual or alleged, or presumed. The legitimacy of their rule rests on the belief in and the devotion to the extraordinary. The source of these beliefs is the proof of the charismatic quality; through miracles, victories and other successes, and the welfare of the governed. Therefore such beliefs and claimed authority resting on them disappear as soon as they fail to prove. An organised group subject to charismatic authority is called a charismatic community. It is based on an emotional form of communal relationship (Kalberg, 2005).

Since it is extraordinary, charismatic authority is sharply opposed to rational and mainly opposed to bureaucratic authority and traditional authority. Bureaucratic authority is rational in the sense of being bound to intellectually analysable rules, while charismatic authority is irrational in the sense of being foreign to all rules. Traditional authority is bound to precedents handed down from the past and, to some extent, it is also oriented by rules. It recognises no appropriation of positions of power under the possession of property either on the part of a chief or of socially privileged groups. The only basis of legitimacy for it is personal charisma so long as it is proved. That is as long as it receives recognition and as long as the followers and disciples prove their usefulness charismatically. The charismatic authority has a character specifically foreign to everyday routine structures in its pure form. The social relationships directly involved are strictly personal based on the validity and practice of charismatic personal

qualities. Suppose this is not to remain a purely transitory phenomenon but to take on the character of a permanent relationship. In that case, the character of charismatic authority must be radically changed. It cannot remain stable but becomes either traditionalised or rationalised or a combination of both (*ibid.*).

The motives behind the transformation are of two types. One is the ideal and also the material interests of the followers in the continuation and the continual reactivation of the community. The second motive is the still stronger ideal and stronger material interest of the members of the administrative staff or the disciples in continuing their relationship. They are interested in continuing it so that their position is put on a stable everyday basis, both from an ideal and a material point of view. The charismatic authority rests upon a belief in the sanctity of the value of the extraordinary. While traditionalist domination, which rests upon a belief in the sanctity of everyday routines, divided the most important authoritative relations.

Obedience is one of the preconditions of authority and it has resulted from a belief in the quality. Sometimes, it is generated from the devotion to the extraordinary sanctity and heroism of authority that the followers view as exceptional. This type of authority opposes existing values of a society, customs, laws, rules and traditions in that society (Kalberg, 2005). In Kerala, both these authorities are simultaneously used to influence others by the institutions or individuals. Religion and caste-based institutions are linked with the traditional authority of organised religion and charismatic and rationale authority as well. People believe that charismatic authority has supernatural powers and special qualities. These have been used to institutionalise their authority (Allan, 2005).

Religion and caste are very sensitive matters in traditional Kerala society. The oppressed sections from the caste hierarchy had been victimised unequally for centuries. The myth of 'pollution' had been institutionalised and had seen inhuman wild practices in Kerala than any other Indian state (Osella & Osella, 2001; Kabir & Krisnan, 1991; Jeffry, 1976). The clutches of caste and religion is still dominant in the public conscience. Weber says the 'strongest legitimisation' (for example, caste hierarchy) 'will make a social structure inevitable and beyond human control'. The philanthro-capitalists in the state well utilise the sanctity of these identities. The conscious selection of the name of each organisation itself symbolises it. Leading organisations are administered by a group of middle-class sections of society. It is not contrary that these initiatives serve to middle and upper classes in the state. The religion and

capitalist nexus are always keen to keep the authority to widen their market through influencing the public.

Research Questions

1. What are the features of philanthro-capitalism at the global, regional and local levels?
2. Whether such institutions in Kerala use their social identities to influence the people in interacting and the government of the state?
3. How do philanthropic institutions influence the government and the people interacting with them?
4. How do such institutions affect the development of public institutions or government services in Kerala?
5. What are the reflections of this influence on healthcare and medical education institutions in the public sector in Kerala?

Purpose of the Study

To understand the engagement of philanthropic institutions in providing healthcare and medical education in Kerala

Specific Objectives

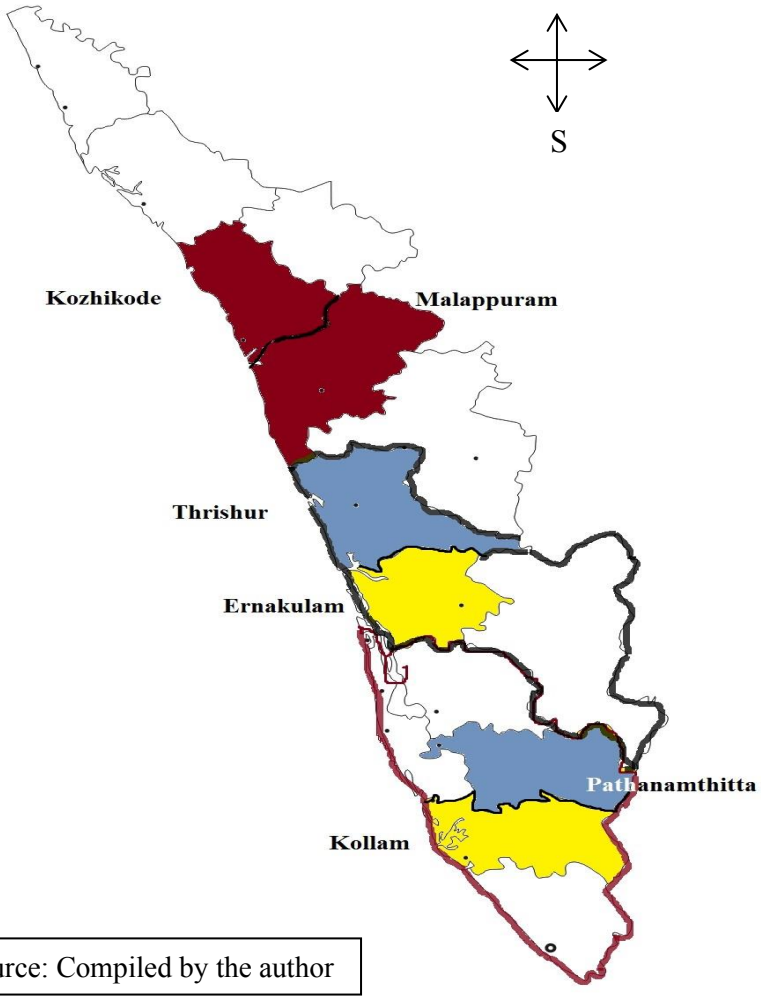
1. To study the characteristics of philanthro-capitalism at the global, regional and local levels.
2. To compare the development of philanthropic and public sector institutions in Kerala after the economic reform policy in 1990.
3. To compare the philanthropic and public sector institutions that provide healthcare and medical education.
4. To examine the social profile of philanthropic institutions and the seekers of healthcare and medical education and identify the differentials.

Study Area and Spatial Distinctions of the Organisations

In the context of Kerala, the geographical locations of philanthropic institutions are very important. As a primary step, the state of Kerala has geographically categorised according to the historical divisions; Tiru-Kochi in the southern part (bottom) of the state, Kochi at central and Malabar in the northern (upper) side (Figure-1.2). Kerala's Northern, Central and Southern regions have been dominated by institutions run by different religious and caste groups. For

instance, in the region of Malabar, the institutions headed by Muslim groups are widespread in terms of their scope and reach. At the same time, Christians and forward-caste Hindus have more institutions that provide healthcare and medical education services in central and southern regions. Health as a commodity in the market, these forces have some sort of similarity even though they have different religious and caste entities. These institutions uphold the power and authority in a similar way in a society where religious belief has strong roots. It can be studied by using the theories in sociology.

Figure-1. 2 Geographical Location of the Organisations



Source: Compiled by the author

Secondly, as per 2011 census data, there are three major religious groups in the state, Christian, Hindu and Islam which have a good number of followers. The groups which belong to these religions run charity institutions across the states. The institutions led by three major religious groups in the state got an equal chance in the selection based on their long-running experience, scope and outreach among the public. The profit-oriented philanthropic institutions were identified and mapped through a field study carried out in 2018. Based on the random

survey, the researcher identified that numerous trusts registered for educational and healthcare purposes grew after 1990.

The northern region consists of six districts. The philanthropic institutions managed by Muslim groups are dominant in the northern region. The researcher had selected a giant organisation out of these working for the last fifty years in Kerala. It is registered under Societies Registration Act-1860 in Kozhikode district (Figure-1.2) and exempted from income tax under section 10(23c) (IV) and entitled to receive foreign funds legally under 80G & 12A of Income Tax-1961. The foundation has been running a medical college hospital with 'exclusive modern facilities', hundreds of schools in India and abroad and acquired vast assets during the period. The tertiary care hospital is a *"multidisciplinary medico network"* started in 2003 in Malappuram district (Figure-1.2). It includes medical college, teaching hospital, dental and nursing colleges. National and state statutory bodies have recognised it. Altogether 400 seats are available for MBBS, dental and nursing colleges. It has achieved awards for academic excellence and produced top rank results in medical examinations.

Central Kerala consists of four districts: Ernakulam, Thrissur, Idukki, and Kottayam. Christian and Nayar (one of the dominant castes in Hindu religion) dominated philanthropic institutions are concentrated across the region. Christians administer more schools and colleges registered under any trust associated with church or diocese. One of the largest Christian missionary organisations with an international base works under the leadership of a Keralite enlisted in the top fund receiving charity foundation. The researcher selected it for the study, a sister institution of the selected organisation as a charitable trust located in Tiruvalla in Pathanamthitta district (Figure-1.2). It was registered under Trust Act-1882 in the year of 1993. The foundation focuses on poverty alleviation, literacy programmes and income-generating projects. It also runs a chain of schools, colleges and hospitals to provide educational and health services in Kerala. Earlier it was located in the Thrissur district (Figure-1.2). Currently, it is not working in India due to the alleged fraudulent activities and legal suits filed in Kerala.

The hospital is a healthcare project of the organisation. The 'Metropolitan' of the Church is the patron of the selected hospital. The hospital is on 25 acres in Thiruvalla, an 'NRI town' in the Pathanamthitta district. The Church is dynamically involved in various nation-building social and educational projects, healthcare initiatives, charitable activities, community development programs, rehabilitation projects and relief work.

Thirdly, 'the Ashram', a charity foundation from south Kerala, has been selected purposefully. It was registered under Trust Act in 1988. It is an international charitable foundation located in the Kollam district of South Kerala. According to Home Affairs, the Ashram is the third-largest foundation receiving foreign funds during 2014-15 and consecutive years. (Figure-1.2). It runs a 'highly sophisticated' medical college and tertiary care hospital in Kichi, Ernakulam district. A Hindu priest founded the organisation in 1981 and an international spiritual leader who is a self-acclaimed god-woman in Kerala. 'A trust' is the sister organisation working in the humanitarian field, including healthcare, disaster relief, environmental protection and education sector. It has been associated with 40 diverse organisations around the world.

Hence, the study was conducted on the selected institutions from these regions. The respondents are from the same institutions ranging from care receivers to officials of the hospitals and trusts.

Inclusion and Exclusion Criteria

Indian constitution legitimises and considers it a fundamental right to form an association and organise a union under Article 19. However, there is a separate entity for a not-for-profit organisation in the Indian legal context. There are many acts in India under which societies, trusts and other philanthropic initiatives can be registered. Some of them are Societies Registration Act-1860 (SRA-1860), India Trust Act-1882, Charitable and Religious Trusts Act-1920, Public Trust Act-1950 (PTA-1950) and section 25 of the Companies Act-1956 (CA-1956). According to Indian legislation, a non-profits organisation is defined as,

> *"Legal or social entities created for the purpose of producing goods and services whose status does not permit them to be a source of income, profit or other financial gains for the units that establish control or finance them. In practice, their productive activities are bound to generate either surplus or deficits, but other institutional units cannot appropriate any surplus they happen to make."*
>
> (GOI, 2014)

The definition clearly states that a philanthropic organisation registered as a non-profit shall not be engaged in making a profit directly or indirectly and surplus should return to agencies and not to its members (*ibid.*).

In the context of Kerala, two Acts have been considered. The associations, societies, or NGOs registered under these Acts have been considered for the study.

a) Societies Registration Act-1860: This Act is a Federal Act (*ibid.*) that legitimises the registration and functioning of societies and associations. The Act is supposed to promote education, literature and scientific knowledge. Some states have not been following the Act and passed their acts. However, Kerala has strict rules to register under the Act.
b) Indian Trust Act-1988: A trust can be public or private. Public trust is made for charitable activities that benefit the public or are made for religious purposes. For example, *Wakfs* have come under this Act (*ibid.*).

In this study, philanthropic foundation or institution is referred to as an organisation registered as society or trust under Society Registration Act (SRA-1860) or under Indian Public Trust Act 1988 (PTA-1950), which are exempted from taxation and or benefits subsidies from the State in the form of land or grant. Religious, secular, civic and or corporate bodies in the healthcare and medical education sectors formed for charity purposes are also an appropriate sample of the study. They receive public or private grants in money or other forms for philanthropic activity. The selected organisations manage hospitals and medical institutes.

Reasons for Selecting Three Different Organisations

A philanthropic foundation struggles against human miseries regardless of religion, caste and other socio-economic differences. Organisations from the three different religious groups interact with respective believers using cults, symbols and other power relations seen within that particular religion. Three organisations have different power equations with state, followers and beneficiaries. The growth of each organisation is at a different pace. All these organisations' parent body is registered in a different geographical area other than the healthcare facility or medical college is located, which demands more investigation. They are concentrated at specific urban locations in Kerala. The prejudiced geographical concentration of the institutions exposes the for-profit intention, nature and exercise of power and authority. The three locations have different socio-political histories and unequal development as well. It also contributed to the development of philanthropic institutions at respective locations.

The southern part of Kerala had been under the caste-based ruling of Maharajas. The state and Hindu caste interplay have a long history in society. The rigid caste system was one

of the significant attributes in Kerala noted by European visitors and scholars. The "staunchly rhetoric Hindu state" stopped the oppressed caste from entering public schools, hospitals, and roads. Robin Jeffrey (1976) says on pre-modern Travancore that: -

> "*their people enduring unrelieved miseries, their rulers pursuing unspeakable pleasure*. *However, in others, there were vigorous political movements involving large numbers of men* (of course, women also there). *Their course influenced far more by the peculiar nature of the princely state arena than by development in British India. Such a state was Travancore whi*ch *roughly corresponded to the southern half of today's Kerala."*
>
> (Jeffrey, 1976 p. 3)

It resulted in the formation of different civic bodies to fight back caste exploitation, denial of rights and political participation. Christian missionaries and charity activities backed by the British Government also developed side by side. While in the Malabar region, such initiatives were comparatively less in earlier times. At the beginning of the 20th century, some Muslim organisations had come up with institutions.

After the formation of the state, organisations from three major religions and caste groups had begun to organise socially and politically in a more advanced way. In the political arena of Kerala, no single party can stand alone and contest for power, but an umbrella of regional parties emerged out of this. Consequently, there developed a power relation between caste, religion-based organisations and political parties. It created a trade-off between institutions and political parties. The relation is evident in all initiatives, which need to be analysed in detail.

Source of Data

The source of data can be categorised as primary and secondary. The primary data was collected from the officials and beneficiaries of the foundations. The beneficiaries include medical students, care seekers and caregivers in the institutions.

The secondary data source contributed to developing the background information of the study. It is used to substantiate the idea of philanthropy at global and regional levels, which has been added to the literature review. It includes archival material from the university and state libraries in Kerala, former studies associated with the same idea or content, regional and

national newspaper reports and videos of academicians from YouTube. Internet is a good source of data which ranges from government reports, income tax reports, Acts and amendments and international archives and online books.

METHODS OF DATA COLLECTION

As a first step, the state of Kerala was divided into three geographical divisions as North, South and Central Kerala. Along with these divisions, the distribution of religious, caste groups in these locations was identified during the preliminary field visits. A primary analysis has been done on the concentration of bigger philanthropic organisations which provide healthcare and medical education in each division. Based on this, a social mapping of organisations has been completed in which the researcher identified each organisation run by particular religious groups. Finally, three organisations were purposefully selected from the list based on their long-running working experience, a wide range of assets, growth and locations.

In each institution, there are four kinds of respondents (Table-1.2). The researcher contacted the Public Relations Department (PRD) and communicated the purpose. Those who did not connect over the telephone were approached physically. An abstract of the study and tools were mailed as per the demand.

The PRD then transferred it to the medical college principal, while another suggested meeting the deputy to the hospital administration's head and meeting them personally. After negotiations with all three institutes, permission was granted to execute the study under certain conditions laid down by the institutions. The administration provided a list of selected care receivers then the study had to be conducted among them in a given time. The researcher was asked to keep the anonymity of the users and all other respondents. At the same time, it was allowed to give a prefix or suffix, be it responsibility or position or rank.

In one institute, the deputy suggested a block and wards where the duty nurses provided the names and rooms of the inpatients assigned for the interview. The researcher interviewed the care users who were in better health condition and could talk freely. However, in other conditions, the bystanders were interviewed. While in the other two institutions, the users' list was prepared with the help of duty nurses and an interview was conducted. The out-patients were randomly selected after they expressed willingness to participate in the study.

The medical college principal permitted the study among third-year students from MBBS and final-year students from other streams. The students approached the researcher after the direction of their teacher and responded to the interview from two institutes. The researcher ensured to cover students who got admission in Non-Residential Indian (NRI) and management quotas. One institute had given students' register and every second student got selected out of fifty. The inclusion of quota students was ensured by directly asking them using the snowball method.

Healthcare givers from every institute were selected based on their long experience in that hospital. A healthcare provider gave information about the new respondent. Five respondents from each hospital (5*3=15) were supposed to participate in the study, including doctors, nurses, and healthcare technicians. However, two of them could not give interviews due to administrative hurdles in the hospitals.

In the case of administrative officers of the trusts or hospitals, it was not easy to interview the key persons. However, five from two trusts and three from another had given the appointment. Two appointments were cancelled due to a media controversy on one of the trusts during the period and they were reluctant to address any externals. Hence the supposed 15 ended in 13 respondents. The researcher listed five persons from each trust from the trust's website and approached the office to interview. The list of one organisation was prepared based on the hierarchy given on the website, while the other two were informed based on the purpose and gave an alternative list for the interview.

The researcher selected care receivers for the case studies using the previous users' list. Nine users were interviewed for case studies (3*3=9) and hence the researcher ensured equal representation of each hospital.

Tools of Data Collection

To meet the study objectives, the researcher developed specific tools for data collection. There are three institutions and four kinds of respondents and hence four sets of tools were designed (Table-1.2). One is a semi-structured interview schedule to interview the users of each hospital. It covers questions on care receivers' socio-demographic information, health, religious belief and practices. Another set of the schedule was designed for students of each medical college in which questions on academic details and fees along with personal details

are included. Interview guide along with the checklist for officials and caregivers has been used.

Table-1. 2 Tools used for Different categories of respondents

Category of Respondents	**Type of tool**	**Number of Respondents**
Care users	Semi-structured interview schedule	91
Healthcare givers	Interview guide along with the checklist	13
Administrative officers or officials	Interview guide along with the checklist	13
Students	Semi-structured interview schedule	92
Case studies of the users	Interview guide along with the checklist	9

The in-depth interview method is grounded on a checklist of concerns on philanthro-capitalism such as the emergence of the organisation, its socio-political transformation, major milestones and their perception of charity, government services and general development issues in Kerala. However, questions during the ongoing narrations had also been aptly put.

Above all, observation is a key tool of data collection for the study. It includes observing the institutions and their premises, their routine and infrastructure. The staff pattern, their social identity and power structure are also observed. The observation was helpful in the theoretical analysis of the study.

Sample Units of the Study

A total of 91 respondents belong to the users' group, in which a minimum of 30 from each institution was ensured (Table-1.2). They gave personal information about their social identity, disease, choice, and perception of the hospital and organisation. Healthcare givers are either nurses or doctors. One technician from each hospital was added to the caregivers' group. They contributed to the data on the technological strength and development of the hospital over the period. Administrative officers directly representing the trust or hospitals are 13 in number from the expected 15. Another category is graduating and post-graduating students from different streams, including allopathic, nursing and dental. Altogether 93 students responded to questions regarding personal information, social information, education fees, job opportunity, bank liability and economic background. The researcher purposefully included students from management and NRI quotas to cover various fee structures of an institute. Nine case studies are interpreted to elaborate the themes of the study (Table-1.2).

Analysis Plan

The data was collected for fieldwork from July 2018 to March 2019. The collection was interrupted multiple times due to the Nipah virus outbreak and the deluge that shook Kerala. After completing data collection, the researcher proceeded to process the raw data for analysis. The process included both manual and electronic work for editing, categorising, and coding as an initial step. Editing helps to correct the errors and filter data properly. Later each variable in the interview schedule was given codes for statistical analysis. The collected data were tabulated by using software like Excel and SPSS. It helped to find frequencies and percentiles of the variables. The researcher developed figures and tables to articulate the relationship between variables and substantiate it using the same software. In addition, in-depth interviews and case studies have been recorded manually or electronically with the respondents' permission.

Two chapters are developed for the analysis of field data in which one deals with social and demographic data of care seekers and the other analyses medical education using responses from the students. In-depth interviews and case studies are used to develop different themes related to the study's objectives. At the same time, the researcher also carries out the analysis based on the information obtained from secondary sources.

Ethical Considerations

The researcher explained the purpose of this study to officials and respondents. The selection of each unit was confirmed only after ensuring prior oral consent. The identity of the respondents will not be disclosed at any stage of the study. Nobody was forced to participate in the study and was free to withdraw from the participation at any point of the interview.

This study is not against any religion. It does not intend to harm any particular community's beliefs or customs, but it is sensitive to the respondents' culture, tradition, and practices that are considered with due respect. Every respondent was informed that there are no adverse consequences if they discontinue the study at any stage.

Chapter Scheme

The central theme of this thesis is based on a phenomenon called philanthro-capitalism. The whole thesis is arranged into six chapters and the contents of each chapter are presented here.

The opening chapter is an extended introduction to the central theme of the thesis titled 'An Introduction to Philanthro-capitalism in Healthcare and Medical Education'. The chapter provides an overall idea about philanthro-capitalism and its development. It begins with a brief background of the study, theories of inequality and power. Both ideas of inequality and power were included in the introductory part because these have vital associations with the emergence and development of philanthro-capitalism in Kerala. The remaining section of the chapter provides a methodological account and contextual knowledge of the study. This section implies the application of Max Weber's theory on authority in the course of the study.

Chapter two is 'Global Context of Philanthro-capitalist Foundation', which provides the global landscape of modern philanthropy. It explains the origin of this idea, the leading proponents behind this movement and a brief account of the global legal scenarios and types of foundations. The chapter also covers details of global contributions, major sectors and countries to which the funds invested by donors and assets of these organisations are also included. Three big organisations of the previous and present century were described to understand the similarities and differences of various foundations at the global and regional levels.

The third chapter is titled ‘Historical Context of Philanthro-capitalist Organisations in India and Kerala’. It provides light into the historical development of philanthropy in India and Kerala. The explanation of regional features of philanthropic foundations helps to understand the Indian scenario in which the association of caste and religion in a charity organisation is well established. This chapter discusses the investment and disinvestment of state government in social sectors, especially in healthcare and medical education. It articulates that the disinvestment leads to the steep growth of philanthro-capitalist foundations in the state.

Chapter four, ‘Evidence from the Field; Analysis of Healthcare Services Provided by the Philanthropic Institutions’, analyses the data collected from various respondents in hospitals. It specifically describes respondents' social and economic characteristics, their interaction with institutions and healthcare services in the hospitals run by the respective parent foundation.

The next chapter, ' Evidence from the Field; Analysis of Medical Education in Philanthropic Institutions in Kerala’, deals with data collected from students of medical colleges run by the respective parent foundation. It analyses the respondents' social, regional, and economic details and education fees in medical colleges.

Then Chapter six, ‘Authority and Legitimation in Religion and Caste-based Philanthro-capitalist Foundation in the Light of Weberian Theory’, is a comprehensive analysis of in-depth interviews of various respondents and interpretation of field observations. It bridges the relation between theory and application of authority in these foundations.

Chapter seven is titled ‘Inference and Discussion’, which concludes the thesis by explaining findings and fusing them with other studies. It gives policy suggestions and scope for further studies.

Chapter 2

Global Context of Philanthro-capitalist Foundations

Over the last two decades, the philanthropic sector and its annual spending have grown in size, so their influence reached beyond the geographical boundaries. Generally, philanthropy is considered a welcome partner of the government in addressing social problems. However, after the significant private wealth creation in the last two decades and the following rise of neoliberalism as a dominant cultural and political ideology, the social sector has looked upon market and business as sources of inspiration to improve the work of public charities (Jenkins, 2011). As a result of the globalisation and privatisation of public sectors, private actors emerged as effective agents to fill the gap in the service sector and accordingly increased their power. They claim that the government cannot solve social issues, but they can. They adopted business techniques in social services.

Moreover, an outcry for Public-Private Partnership (PPP) increased in the last two decades. The private actors gradually became important in the policy discussions of various countries. They started investing in the social sector, which became larger than the government share, especially in poverty eradication, healthcare, education, sustainable development, and the environment (*ibid.*).

Global economic growth leads to the accumulation of substantial private wealth and thus resulting in the global high net worth individuals (HNWI). It is estimated that there are 15 million millionaires and 2000 billionaires around the globe. According to the World Wealth Report (WWR), HNWI surpasses $70 trillion for the first time, and it has grown by 10.6 per cent, which is the second-fastest year for HNWI growth (WWR, 2018). The report says

> *"The HNWI population continued to grow across global regions, with Asia-Pacific and North America accounting for 74.9 per cent of the total global increase in the HNWI population (1.2 million new HNWIs) and 68.8 per cent of the rise in global HNWI wealth (US$4.6 trillion in new HNWI wealth). Europe also realized a strong performance in 2017 with 7.3 per cent of HNWI wealth growth. The largest markets, comprised of the United States, Japan, Germany and China, represented 61.2 per cent of the global HNWI population in 2017 and accounted for 62 per cent of all new HNWIs globally."*

(*ibid.*)

The same private actors have changed their appearance into a new form called "big philanthropy" and claim it to be a very different form of philanthropy. It has an increasing influence on global development policy matters. Today almost all areas of global development are affected by giant philanthropic organisations like Bill and Melinda Gates Foundation. This chapter discusses the development of the 'new form of giving' known as philanthro-capitalism, which evolved in the last century. It also examines their nature and influence in cross border affairs. It certainly has great potential, but the 'proposed means and promised ends' of this philanthro-capitalism are weak in solving social problems.

Many people hesitate to criticise or question philanthropic activities, assuming that it is a voluntary act. Moreover, they believe that as far as it is consistent with law and is working for the public good by spending their private money, there is no need to be concerned. Even if it is legal, many activities should be critically analysed because of their influence over society and violation of other social values (Jenkins, 2011).

The Rise of Philanthro-capitalism

In 2009, forty American billionaires pledged to give half of their wealth during their lifetime for the welfare of human beings, which was inscribed as 'giving pledge'. Many Indian philanthropists took part in the 'giving pledge' disseminated globally by the super-wealthy (also called 'good club') (Rogers, 2011). Another parallel movement is "giving while living", propounded by Chuck Feeney, the founder of Atlantic Philanthropies. The essence of these movements is to give the multibillion-dollar fortune of the world's wealthiest people to charity during their lifetime and achieve more. Later it was termed as Philanthro-capitalism. The movement started with successful entrepreneurs and business tycoons turned philanthropists, and after it flourished globally with the addition of hundreds of foundations and advocacy groups. It was reported that Bill Gates was only concerned with his most profitable business, Microsoft, and had no thought of charity. Later he entered into the world of charity like many others (McGoey, 2014).

The elite club of the world was convened a year before the 'giving pledge' in New York to discuss which social problem should be more targeted by the super-wealthy. The meeting was noted as the most important moment in the emergence of philanthro-capitalism. It is not surprising that they identified population growth as the world's most pressing problem (Rogers,

2011). The underpinning trends of philanthro-capitalism are; it focuses on 'strategic investment' based on 'measurable objectives', spending large sums of private money for 'public good', growing visibility of individuals as changemakers, and the increasing presence of the private sector in social development (McGoey, 2014). The rationale for the philanthro-capitalism proposed by its proponents can be read in this way; the 'super-rich can fare far better than anyone else during this financial crisis, government slashes budget for welfare activities during the crisis hence demand philanthropy will be increased and each dollar for the philanthropy can be used more effectively by the 'business-like approach'' (cited in McGoey, 2012)

At the same time, these capitalists are trying to bury the truth that capitalism created an unequal distribution of wealth and inequality across the world. McGoey argues (2012) that the term itself poses doubt and incongruence. While we divorce the term into 'philanthropy' and 'capitalism', both are contradictory. Philanthropy has been interpreted between altruism and egoism for decades. Social scientists say philanthropy has collectivists' and individualists' traditions (Kidd, 1966). The pre-market society is more central to gift exchange than commodity exchange. It cannot be attributed to economic relationships, but philanthropy enhances social solidarity and legitimises individuals' status in their society. It is viewed as the generosity of some individuals as well (*ibid.*). Hence the altruistic character of philanthropy is never appropriate to capitalism. The idea of capitalism is solely related to the exchange of money and commodity. The primary characteristic of a capitalist system is a commodity economy, that is, an economy produced for the market. Philanthro-capitalism has been used to maximise the wealth of some individuals in the guise of charity (Jenkins, 2011; Ramdas, 2011; McGoey, 2012; Rogers, 2011).

Philanthro-capitalism is an effort to transform organised philanthropy into an efficient and "lucrative industry" (McGoey, 2014). The term Philanthro-capitalism has come into modern lexical in the last decade. It was first used in a magazine, 'The Economist' by editor Mathew Bishop and the former policymaker at Department for the International Development-United Kingdom, Michael Green, in 2006. The idea was later developed in a book they authored in 2008 named *'Philanthrocapitalism: How the Rich Can Save the World'*. From their words, the term represented the new form of doing charity. It mirrors, they continue, *"the way that business is done in the for-profit capitalist world"* (cited McGoey, 2012). The book's

second edition was published in the following year with a slightly changed title *'Philanthrocapitalism: How giving can save the world'.*

Philanthro-capitalism is based on the idea that inequality and other social problems cannot be solved only through government investments, charity, and agitations. However, they require a business that can provide money, management, and innovation. Philanthro-capitalism is a new way of doing business in a for-profit capitalist world. In a nutshell, 'philanthropy is a profitable business' as Rogers points out, one has to start with Money, Market, and Measurement; three 'M's to understand philanthro-capitalism. The super-wealthy has money that is to be spent for the common good. Market forces design effective social programmes and resources which will be used in a targeted way based on data to scale the success (Rogers, 2011). The term has been understood as 'the application of business tools in charity' (Jenkins, 2011; Edwards, 2008), and it is believed that business methods will give solutions to social problems. Philanthro-capitalists' promises social transformation through effective use of wealth and capital of the 'most generous people in the world. The scholars of philanthropy state that 'it is a movement different from traditional charity to more strategic giving' (Johnson, 2013).

Entrepreneurs, the champions of philanthro-capitalism, aim to apply business methods in social problems. They claim to transform 'outdated and inefficient charity activities' into modern philanthropy. The new thing about philanthro-capitalism is the unprecedented size of money flow in the history of charity despite the growing economic crisis in the world (*ibid.*). The media in the U.K and the U.S.A had reported on the financial crisis followed by the shutting down of Lehman Brothers Holdings in 2008 that it seems to be 'the end of capitalism'. The authors say about the crisis, *"some people have commiserated with us for our timing, launching our book, just as capitalism is falling apart. But we believe the financial crisis makes our message more timely than ever"* (*ibid.*). However, the economic crisis ultimately benefits the richest of the world; from the beginning of the crisis, the net worth of these people increased every year. Various Forbes reports show that wealth concentration steeply increased despite the shrinking economy. They are the investors of new philanthropy.

Based on the Organisation for Economic Cooperation and Development (OECD) report, Non-governmental Organisations (NGOs) and private foundations contributed six per cent of the total flows from the OECD committee to the 'developing countries' account in 2012. It comes to around US$29.75 billion (cited in Martens and Seitz, 2015).

Table-2. 1 The World's Ten Largest Philanthropic Foundations (Based on assets in 2014)

Rank	Foundations	Assets (Billion)	Annual Giving	Inception
1	Bill & Melinda Gates Foundations	42.9	3.9 Billion	2000
2	Wellcome Trust	29.8	1.1 B	1936
3	Howard Hughes Medical Institute	18.6	917 Million	1953
4	Garfield Weston Foundations	17.3	89 M	1958
5	Ford Foundation	11.9	570 M	1936
6	Kamehameha Schools	11	378 M	1887
7	The Church Commissioners England	11	354 M	1948
8	Robert Wood Johnson Foundations	10.5	408 M	1972
9	J Paul Getty Trust	10.1	268 M	1982
10	Lilly Endowment	10.1	326 M	1937
26	Rockefeller Foundation	4.1	156 M	1913

Source: Martens & Seitz, 2015 and Foundation Centre, 2015

Another projection says US$55 trillion in the philanthropic sector are expected in the US alone in the coming forty years. The investigation is interesting on the 'magic stick' which can cumulate the wealth of these individuals, day by day while almost all nations face economic crisis and inflation. On the other side, the earnings of the poor are not increased accordingly! Wealth is concentrated just among a few and widespread social disparities persist everywhere. It is reported that more than ten per cent of the global poor live on less than US$1.90 in a day, among which half of the poor live in Sub-Saharan Africa (Johnson, 2018).

Champions of philanthro-capitalism encompass many eminent personalities, from former U.S president Bill Clinton to Bill Gates. The ex-president claimed that "*the profit motive could be the best tool for solving the world's problems, more effective than any other government or private philanthropy"* (Cited in Edwards, 2008). They redesign the strategy,

operation, and efficacy of the 'medieval' charitable sector. They argue that capitalism is philanthropic and good for humanity by giving back from their augmented wealth. The claim is that capitalism itself can be philanthropic and that it gives benefits to all through innovative products with higher quality at a lower price (McGoey, 2015). The argument is that business methods can transform society, but they are silent on whether it increases access to public goods and services or reduces inequality.

Bill & Melinda Gates Foundation (BMGF) is the largest foundation in the world in terms of assets and spending (Table-2.1). Even after the growth of philanthropic foundations worldwide, U.S philanthropy predominates overall in terms of number, assets, and annual spending. Most philanthropic foundations are concentrated in Europe, North America and other high-income countries. Global Philanthropic Report identifies that 60 per cent of the foundations are geographically concentrated in Europe and 35 per cent in North America. Almost 90 per cent of the foundations are concentrated in the highest income countries (Johnson, 2013 and 2018).

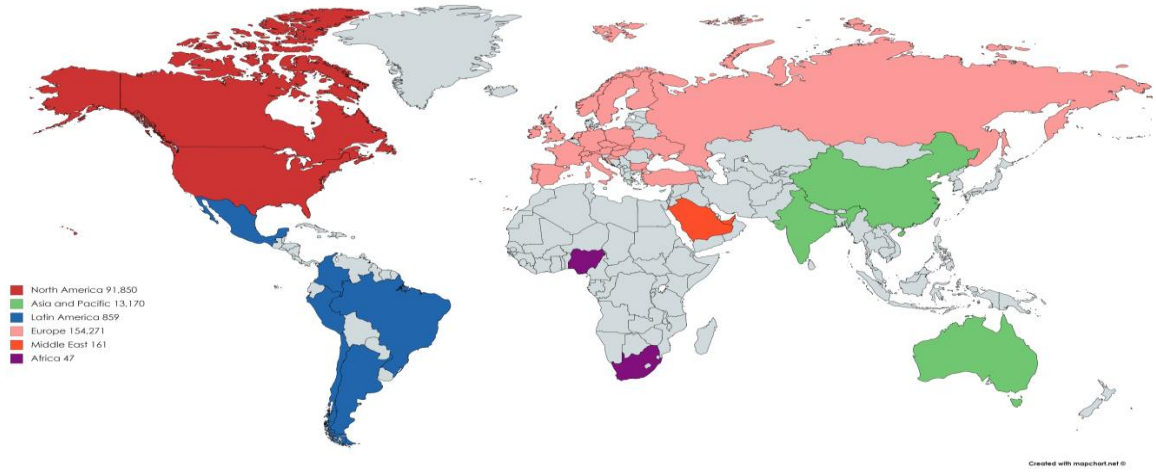
Global Landscape of the Philanthropic Foundations

While charity has long cultural traditions, the new philanthropic sector is young. In most of the world, data on philanthro-capitalism is scarce because neither the government nor the nongovernmental agencies make it publicly available. The available data is not comparable across countries due to inconsistencies and epistemological differences. The literature identifies that 268,000 foundations are working worldwide (Johnson, 2013). The data is more comprehensive for Europe and North America than other regions due to the paucity of data.

Europe is home to more than 154,271 foundations. Within Europe, there are considerable regional variations of the numbers like 20,700 in Germany and 12,700 in the United Kingdom, while in Ireland it is lowest as 40 (Figure-2.1). The second highest in North America with 91,850 foundations in which the United States has 86,000 foundations and dominate the world in the case of philanthropic foundations. In Latin America, 859 organisations have been identified. In Asia and the Pacific, 13,170 foundations are functioning, among which China has a higher number of organisations-5000, while India has only 500 big foundations. Saudi Arabia dominates with 121 foundations out of 161 in the Middle East (Compiled from Johnson, 2013, 2018; Foundation Centre, 2015; OECD Report, 2015). At the

same time, 90 per cent of the philanthro-capitalists foundations are independent or family foundations.

Figure-2. 1 Global Landscape of the Philanthropic Foundations



Compiled from OECD, 2018; Foundation Centre, 2018; Johnson, 2013

It is identified from various reports that 60 per cent of the foundations are in Europe and 35 per cent in North America. It is evident that 90 per cent of philanthro-capitalists foundations are concentrated in 25 high-income countries (Figure-2.1). Regarding the age of these foundations, 72 per cent of them have been registered in the last 25 years is. It proves that institutional philanthropy has been growing in the last three decades than ever before.

Legal Identity of Philanthropic Foundations; A Global Scenario

The legal environment for philanthropic foundations may vary around the globe. It ranges from legal identities, registration, government supervision, and tax. There are countries with a higher favourable policy environment for philanthropic foundations and there are legal, government, and tax interventions in some other countries. In many countries, there is not much distinction between philanthropic foundations and civil organisations (Johnson, 2013). Latin America has relatively a 'weak legal distinction' between foundations and civic organisations. In addition, philanthropic institutions do not have an independent legal identity in America. North America is room for various forms of investments in the name of charity like Programme Related Investing (PRI), Mission-based Investing (MRI) and Socially Responsible Investing (SRI). Hence, the legal identity of such organisations has varied than in any other place (*ibid.*).

On the other hand, some countries have strict supervision on activities such as funding and expenditure of philanthropic foundations. In contrast, others are keen on not creating hurdles in the activities. Kenya is considered an example of the former one and South Africa is for the latter. At the same time, there are countries with dedicated administration in this sector in which different agencies are involved in registration, licensing, and monitoring the financial activities of the foundations. Arab and some other Asian countries are examples of this.

India is favourable to philanthropic activities and has a certain set of rules and agencies. However, organisations enjoy the maximum benefit in the state. The tax policy in the country has been designed, including private tax exemption, to encourage individuals and companies to contribute to philanthropic activities. Arab countries also deduce charity contributions from taxable profits like India does. At the same time, WINGS reports that South Korea has a strong tax policy environment considered "highly complicated and confusing laws".

Europe and North America have a 'most favourable' legal environment for charitable organisations' functioning and financial activities. However, they believe that this favourable condition is limited within the countries only; cross border philanthropy has many barriers in Europe as well. Philanthro-capitalist foundations expect no intervention from the state in the charity activity like a 'free-market' world.

Typology of Philanthropic Foundations

The philanthro-capitalist foundations may vary in type. It can either be a trust or foundation or a school headed by individuals, private companies, and many others. Hence, the organisations differ in type, purpose, and priorities. Some may operate at a ground level, others do advocacy activities, and others do grant-making and funding. There is no single universal definition to understand a philanthropic foundation. Generally, the distinction between private and public foundations can be made in this way; a private foundation has its endowments. The fund donors are either individuals or families.

On the other hand, public foundations have multiple sources for fundraising, including public contributors (Foundation Centre, 2015). The scholars refrain from giving a concrete definition of philanthropic organisation. However, they have drawn a criterion that can be read in this way; an organisation, non-governmental in nature and stands not-for-profit. They must promote charity activities for the public good by the self-managed trustees, directors and

volunteers (Edward, 2008; Jenkins, 2011; McGoey, 2012; Martens&Seitz, 2015). There are four criteria in most of the definitions;

1. Non-governmental
2. Not for profit
3. Self-managed by trustees and board directors and
4. Aiming welfare of the people by charitable activities

Foundation Centre is, as it claims, a leading and reliable source of information about philanthropy (Foundation Centre, 2015, Johnson, 2018). The Foundation Centre has classified philanthropic foundations into four types (Table-2.2).

1. Independent Foundations: This type of philanthropic foundation is established by individuals or families and the source of the endowment is from individual donors or families. They are largely engaged in grantmaking activities. Independent Foundations constitute 92 per cent of the total foundation landscape. BMGF, GlaxoSmithKline and Rockefeller foundations are some of the examples of Independent Foundations.
2. Corporate Foundations: These foundations are established by major corporates or family groups. These may have separate legal entities in different countries. It comes to three per cent of the total foundations. Wal-Mart is an example of Corporate Foundations. Latin America has the highest number of Corporate Foundations.
3. Community Foundations: These foundations constitute one per cent of the total philanthropic foundations globally. They engage in grantmaking activities in a limited geographic boundary like Silicon Valley and New York Community Trust. They receive funds from public and private sources. These foundations are prevalent in the US and Mexico.
4. Operating Foundations: These are established either by individuals or donor families who run specific programmes and engage in grantmaking like a museum, zoo, and library operation. Only four per cent of the foundations fall under this category.

(*ibid.* and Foundation Centre, 2015)

Table-2. 2 Aggregate Fiscal Data of Foundations

Foundation Type	No. of Foundation	Total Assets (billion)	Total Giving (billion)
Independent	79,489	704	44
Corporate	2,468	28	5.5
Community	795	84	7
Operating	3,451	44	6

Source: Foundation Centre, 2015

Recent statistics show that over 260,000 philanthropic foundations are working in the world. Around 86,000 foundations have been registered in the USA. It is calculated that 85,000 foundations have been registered in Eastern Europe and 35,000 foundations in Western Europe. The Global South has also shown substantial growth in the registration of the foundations, especially in Mexico, China, and Brazil (Martens& Seitz, 2015). The philanthro-capitalists invested in multi-sectors mainly in healthcare, agriculture, education, research, technology, tobacco products, beverages and even mining in the sub-Saharan region (McGoey, 2012). There are also debates on the accountability and discrepancy over the funding source and investment of philanthro-capitalist organisations (*ibid.*).

Changes in the Phraseology Over the Periods

Philanthro-capitalism is a comparatively new phrase of organised giving, which was evolved through various terminologies. Charity represents the unorganised form of giving and was a widely used term till the industrial revolution. Then philanthropy was used to denote an organised form of charity. Theoretically, philanthropy and charity are different connotations. The association between philanthropy and capitalism starts in the industrial period.

The term 'Community Foundation' was one of the old nomenclatures used in literature for charity organisations. The community foundations are public charities dedicated to the public good in a definite geographical area. They channelise financial resources from individuals, families and communities from a limited geographical area (Martens & Seitz, 2015). Later, 'social entrepreneur' gained popularity in the last decade. According to the London School of Social Entrepreneurs (LSSE), "a social entrepreneur works in an

entrepreneurial manner but for public or social benefit rather than to make money". One of the top social entrepreneurs, Ashoka, says (2019) that *"people solve social problems on a large scale... that are transformative forces"...* can be called a social entrepreneur. The literature points out that community foundations and social entrepreneurship are formed in democratic ways and always inclusive (Emerson, 2003 cited in Edwards, 2008).

In contrast, evidence shows that 88 per cent of such organisations in the USA face difficulties operating in the way that entrepreneurs are supposed to be. They had to compromise their social goals for financial benefits (for more examples, Edwards, 2008). However, scholars have categorised both these types and some others as philanthro-capitalist organisations based on their engagements (Edwards, 2008; Martens&Seitz, 2015). Edwards says (2008), *"19th Century capitalism included space for many enterprises that existed for social as well as business goals including cooperatives, mutual societies and building societies"* (Edwards, 2008 p.15).

Family Firm Philanthropy (FFP) is another term that denotes 'donations of resources to social development' to control the respected family (Bhatnagar et al., 2019). The driving forces behind FFP are social recognition, control and status. They are primarily corporate business groups and legally obliged to donate a share of the profit, generally considered corporate social responsibility (CSR) or corporate philanthropy (*ibid.*). However, some of these firms exceed legal target of CSR. In India, the CSR law was amended in 2013, which mandates all firms to spend 2 per cent of the annual net profit.

Evolution of Terminology: Philanthro-capitalism

A series of novel ideas, including microcredits, impact investment, social entrepreneurship, and finally philanthro-capitalism, are arrayed in a 'new bottle'. Even if the idea of microfinance, entrepreneurship, and philanthro-capitalism were born in the same period, there are differences as well as similarities between these. While the term 'Philanthro-capitalism' has recently seeped into the world lexical, the scholars say that the trend is not novel. Philanthro-capitalism represents a new market strategy for profit augmentation. As Adam Smith asserted, the free market can contribute to the development and as a result, poverty will be eliminated from the bottom half. A very similar argument has been raised by its proponents again, that philanthro-capitalism would bring welfare of people (Edwards, 2008; McGoey, 2012).

Social enterprise or social entrepreneurship is a growing concept and a dynamic movement that has gained significant attention in the philanthropic sector and literature. Both of these concepts can be used or defined in different ways. Social entrepreneurship has been connected with public charities formed by socially-minded individuals thinking about *"how philanthropy might work (differently and) about how they could take what made them rich in business and apply those tactics to charity"* (Kerr, 2007). The idea of entrepreneurship originated in the 1990s and is intended to generate earned income through commercial revenues and users fee (Jenkins, 2011). Social enterprise is used to denote for-profit corporations focused on *"ventures seeking "a double bottom line," that is, the pursuit of both social impact and financial reward through the delivery of services or products"* (*ibid.* p.10).

Philanthro-capitalism has tried to apply the same methods and principles in the private foundations. The initial stages of these efforts of applying business methods in social issues led to the new "venture philanthropy", a form of engaged grantmaking. Professor Thomas Kelley refers to it as "the better-funded doppelganger of social entrepreneurship" (*ibid.*). However, philanthro-capitalism is a more advanced version of venture philanthropy. Social entrepreneurship can satisfy both the social and financial interests of investors and public corporations. It generates two interrelated outcomes: social progress and financial return through strategic investments. Entrepreneurship gained momentum and legitimacy at a juncture when the government slacked off in resolving social issues (Kerr, 2007).

Impact Investing and Strategic Giving

Impact investing and strategic giving are two terms associated with philanthro-capitalism. It means capital investment focussed on social impact and the public good. It also includes socially responsible investing, which sieves out socially harmful investments like tobacco, arms, and alcohol (Nicholls, 2010). After the financial crisis, many policymakers started thinking about how the investment could make a greater social impact. Since it is a recent idea, the earlier notion has changed considerably, or institutionalised philanthropy sacked it. The prominent exponents of philanthro-capitalism, Bishop and Green, realised that philanthropy could be profitable through impact investing. It ensures that business individuals get measurable financial profit by investing in social and environmental projects to provide services to vulnerable social groups (*ibid.*).

As Jed Emerson and Antony Bugg-Levine, the proponents of leading social entrepreneurship, said, "the impact investment's sweet spot is exactly where the limits of traditional philanthropy and governmental programmes begin" (Goldmark, 2011). Their spending is concentrated in selected areas like health (37%), agriculture and environment (11%). On the other hand, it is very meagre in the fields of human rights and legal assistance, which comprises only four per cent (Martens &Seitz, 2015).

> *"Impact investing is the idea that individuals can earn 'market-rate' financial returns for investing in projects geared at providing environmental and social benefit. A recent report from Monitor states that investor excitement over impact investment has been fuelled by a 2010 study from JP Morgan, the Rockefeller Foundation and the Global Impact Investing Network, which predicted that potential profits for investors could range from $183 billion to $667 billion, with invested capital ranging from $400 billion to $1 trillion."*
>
> (McGoey, 2014 pp; 116)

After analysing 5000 potential companies for ten years, the report also observed that the profit-oriented investors are hardly interested in 'risky ventures' and areas where the financial benefit is uncertain (*ibid.*). Interestingly, microfinance has been a financially robust impact investment area in the recent decade. It is claimed that the microfinance investors had received "a consistent six per cent return" even after the financial crisis. At the same time, there is sufficient literature substantiating the adverse effects of microcredit or microfinance that create a debt burden over loan recipients (Banerjee, 2010). Hyderabad is the worst example of over-financial indebtedness due to microfinance. Microfinance has been expanded in India very fastly. It is accused that the microfinance institutions had been "earning outsize profits on the backs of poor" (Polgreen and Bajaj, 2010).

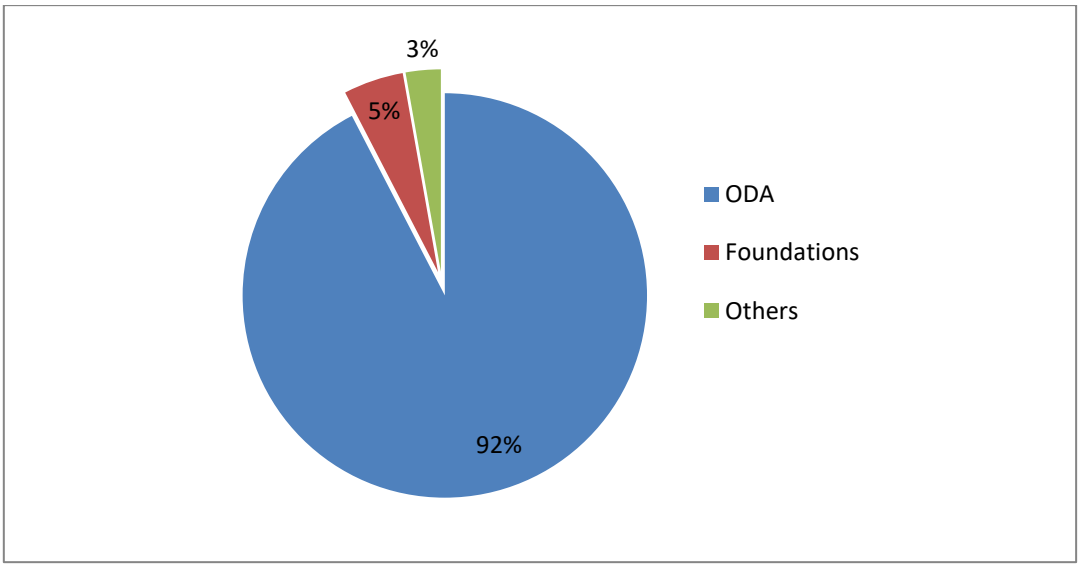
In the case of BMGF, the biggest philanthro-capitalist organisation, investment is more controversial. It simultaneously invests in social development sectors and controversial sectors like McDonalds and Coca-Cola as well. The beverages exacerbate health problems and are sometimes directly linked to human rights violations and environmental degradation.

Estimating the data on philanthropic giving is difficult because it is not systematically collected, so it may vary in different reports and research. The reliable data sources like Organisation for Economic Cooperation and Development (OECD), Foundation Centre and

Global Philanthropic Report can be the dependable sources of information though it needs to be converged. OECD report says that the total flow of the foundations during 2013-15 was $23.9 billion. It is relatively minimal compared to the official spending for the development, which accounts for $469 billion during the same period (Figure-2.2). Official Development Assistance (ODA) is the contribution of the donor countries.

European Union is the highest contributor of ODA while foundations from the USA are the highest contributors of non-ODA funds (OECD, 2018). Undoubtedly, the USA achieved this position because of the BMGF, one of the biggest donors contributing to the 'global development'. In 2012 contributions from the foundations comprised six per cent of the total flows, including ODA and non-ODA (*ibid.* Martens & Seitz, 2015).

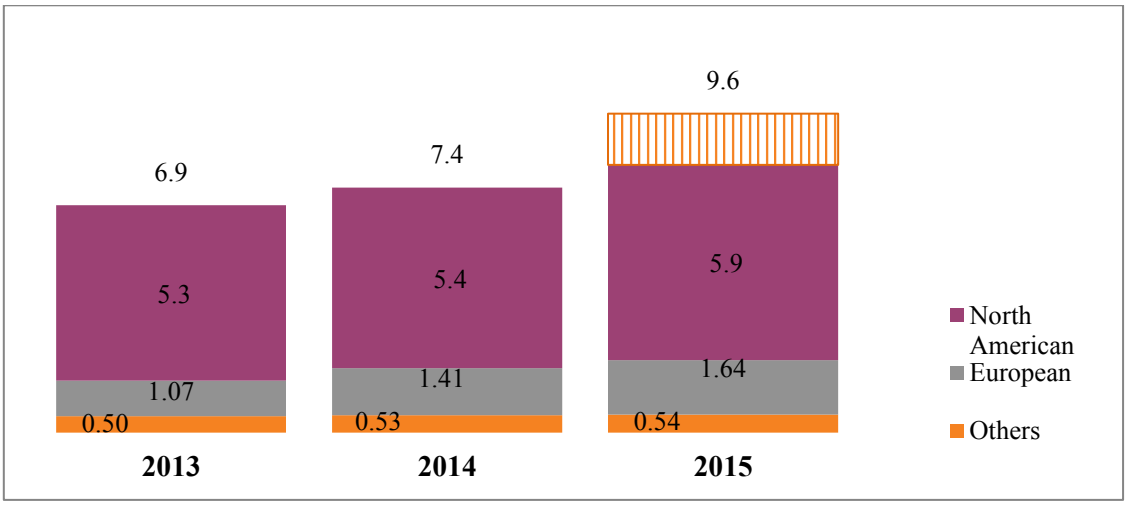
Figure-2. 2 Total Capital Flow for the Development during 2013-15



Source: OECD, 2018

The giving has shown a 19 per cent increase annually, contributed by the foundations from European countries and the single donor BMGF. European foundations' giving in 2015 had increased 53 per cent than in 2013 (Figure-2.3). Foundations from the United States had a share of two-thirds of the total giving. Almost half of which is contributed by the BMGF (*ibid.*). The United States' total giving has increased steeply from US$2 billion to US$14 billion from 2002 to 2015 (Foundation Centre, 2015). It means that philanthropic spending has grown considerably in the last decade and is a still-developing sector.

Figure-2. 3 Contribution of Philanthro-capitalist Foundations over a period (billion $)

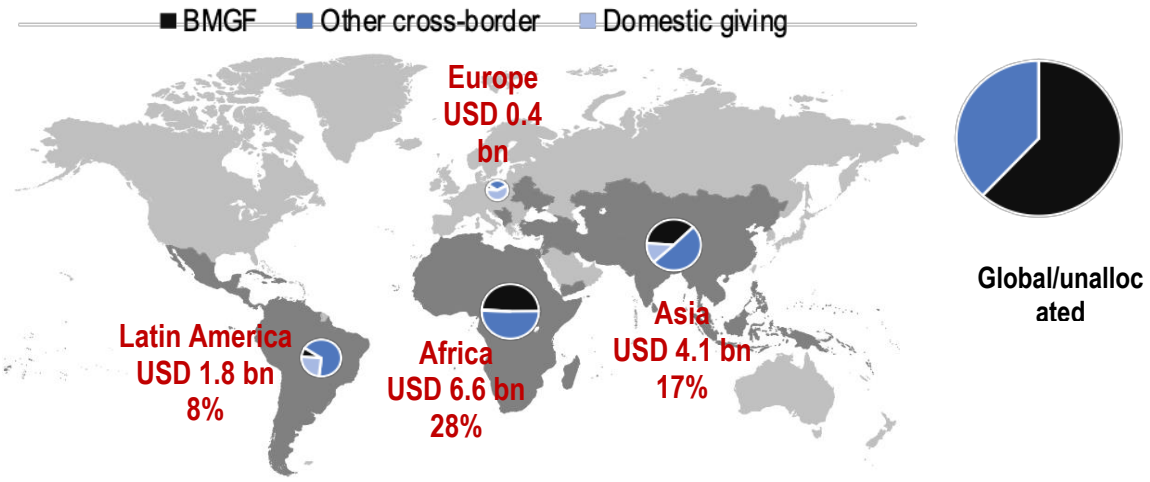


Source: OECD, 2018

Geographical Understanding of Giving

European and American based foundations have been spending a large sum of money to different parts of the world and it is varied across regions (Figure-2.4). Based on reports, annual expenditure is $150 billion, which includes the operational expenditure and administrative costs of a foundation as well. Average charitable spending for a single foundation crosses $1 million annually (OECD, 2018; Johnson, 2018). The foundations largely concentrate on Africa, where $6.6 billion - almost 28 per cent of the total global giving (US$ 23.87 billion), is concentrated.

Figure-2. 4 Philanthropic Contribution across the world

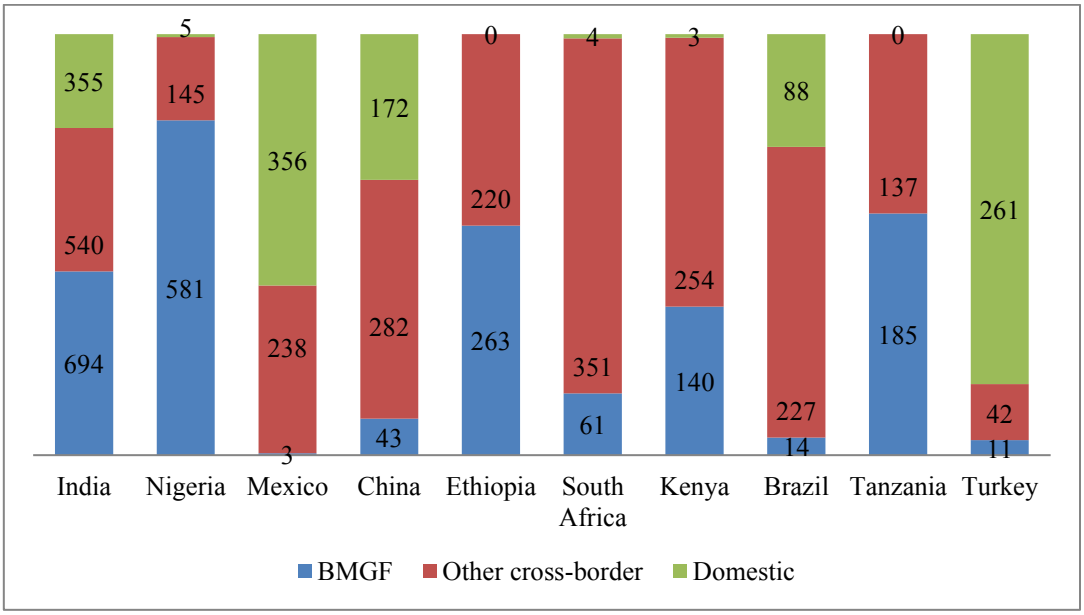


Source: OECD, 2018 p. 42

Asia is the second focus of the giving where $4.1 billion (17%) had been spent during 2013-15. Latin America and Europe had received $1.84 billion (8%) and $0.44 billion (2%) per cent giving respectively. Unallocated global funds came to $10.8 billion (45%), spent in different regions for multiple purposes and projects (Figure-2.4).

While disaggregating the regions, some countries become the centre of focus of philanthro-capitalist foundations. Countries like India, Nigeria, Mexico, and China are ranked among the top ten countries that received the highest funds during 2013-15 (Figure-2.5). India had received the highest amount of $1,589 million (7% of global spending) altogether during the same period. Out of the three funding sources: BMGF, Domestic, and Other cross border foundations, BMGF had given the largest share, which is $694 million, which constitutes 43 per cent of the received fund. Tata Trust is the largest contributor among the domestic foundations working in India.

Figure-2. 5 Top Ten Recipients of Philanthropic Funds (in million $)

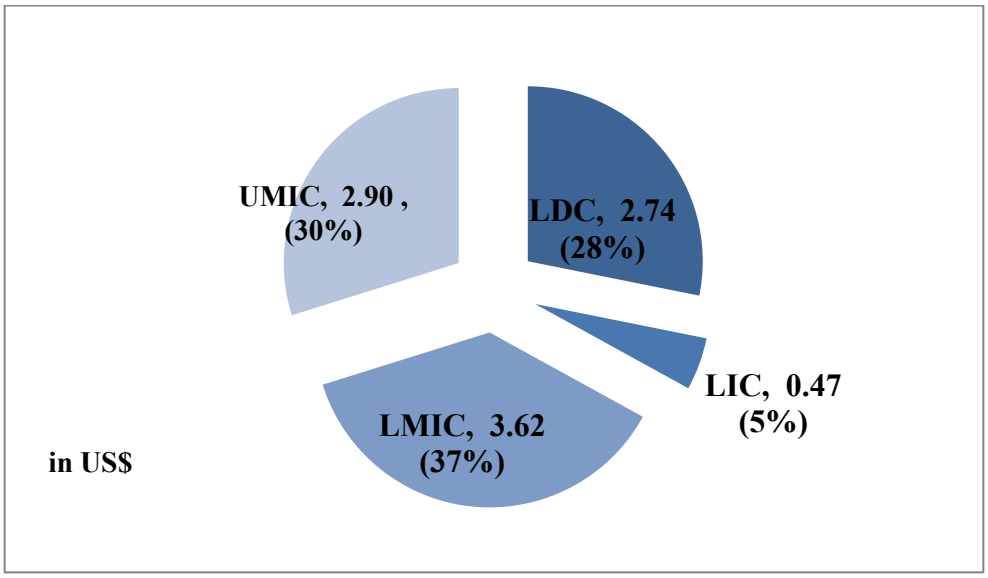


Source: OECD, 2018 p. 43

The domestic foundations have spent 22.3 per cent of India's total fund. Nigeria is the second-highest country that received $730.36 million (3% of the global). BMGF has a special interest in Nigeria, where their share is 43 per cent of the country's total $730 million. In the case of Mexico, the share of domestic foundations is 60 per cent of Mexico's total $596 million. Besides India, BMGF has been spending a major part of their funds on lower-income countries like Ethiopia, Tanzania, and Kenya, accounting for 55, 57, and 35 per cent of the countries' total received funds (Figure-2.5) (*ibid.* and Johnson, 2018).

On the other hand, data shows that philanthropic giving is not largely directed to the poorest countries in the world; the highest part (37%) of the total flows is directed to the Middle-Income countries (LMIC) (Figure-2.6). Upper Middle-Income countries (UMIC) receive 30 per cent and Least Developed (LDC) and Low-Income countries (LIC) receive only 27 per cent and 5 per cent, respectively (Figure-4). It shows that 67 per cent of the total flow is directed to the Middle and Upper-Income countries, which substantiate the critiques that most of the philanthropic wealth rotates within the developed regions of the world (Jenkins, 2010).

Figure-2. 6 Flow of Philanthropic Contribution based on Income Groups 2013-15



Source: OECD, 2018 Remarks; UMIC-Upper Middle-Income Countries, LMIC-Lower Middle-Income Countries, LIC-Low Income Countries and LDC-Least Developed Countries

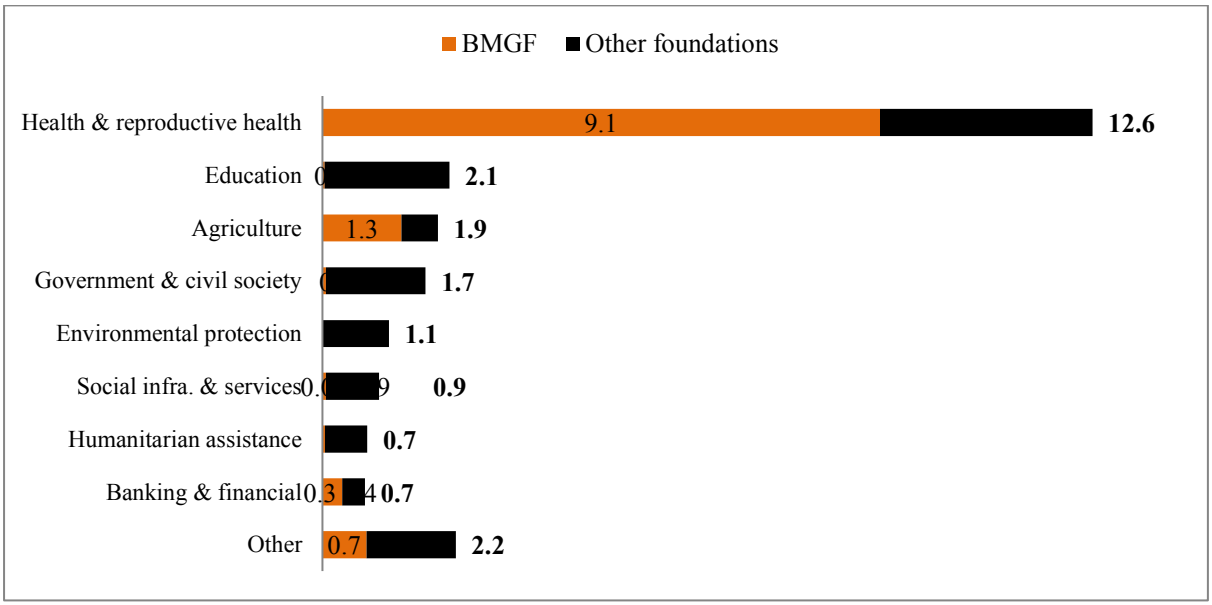
Sectoral Understanding of Giving

The priority area and focus reflect the interest of philanthro-capitalist foundations. It is an undisputed question to philanthro-capitalists that which is the most affected problem in the world. Answers may vary, but philanthropic foundations prioritise population growth, and therefore reproductive health is given more funds and priority (Rogers, 2011). Health and education sectors are the highest priority areas for the foundations.

During 2013-15, these foundations had spent $13 billion for the Health and Reproductive Health Sector, which constitute 53 per cent of the foundations' global spending for the development. Despite the highest number of foundations working on education, the sector had received only $2 billion (9% of the total spending). Environmental protection

received $1 billion (4.5 per cent), which is not an attractive area to the philanthro-capitalist foundations (Figure-2.7).

Figure-2. 7 Foundation Giving by Sector 2013-15 (in billion $)



Source: OECD, 2018 p. 46

BMGF is the most significant contributor among foundations in global health. They had contributed 72 per cent to the health sector and other philanthropic foundations had contributed the remaining 28 per cent. BMGF had contributed 17.5 per cent of their total giving for reproductive health and population control programme. The second highest investment of BMGF is in the agriculture sector, where they had spent $1.3 billion during 2013-15, which constituted 11 per cent of the BMGF's total philanthropic giving (Figure-2.7).

Why are the philanthropic giants, especially BMGF, Ford, and Rockefeller Foundations, more interested in the global health and agriculture sectors? They invest a considerable sum of money in Asia and Africa, particularly in these sectors. Most of the countries in these regions are fertile and depend on agriculture. At the same time, philanthro-capitalist organisations have been accused of influencing the shaping of the global agenda of health, food, and agriculture (Rogers, 2011; Martens and Seitz, 2015). Gates Foundation has been actively involved in agricultural research and policymaking and BMGF has grown to be one of the most influential funders in agriculture. Philanthro-capitalists have discovered that the widespread hunger and malnutrition in the world is primarily because of the lack of scientific intervention and the absence of modern technology. They suggest technological innovations and industrial agriculture (Martens & Seitz, 2015).

They introduced the 'Green Revolution' in 1960, focusing on Latin American and South-East Asian countries and implanted the idea of hybrid seeds, excess use of pesticides and chemical fertilisers. Interestingly, philanthro-capitalists suggest that these 'scientific' and 'innovative' techniques solve global hunger and malnutrition. The entry of BMGF into the alliance came very recently. In 2006 BMGF and Rockefeller launched 'Alliance for a Green Revolution in Africa' (AGRA) and since then, they have become the central point of the AGRA (https://agra.org). Global Alliance for Improved Nutrition (GAIN), founded by Gates Foundation in 2001, was later developed in a session of the United Nations the following year. They provided initial funds for agriculture innovation. By 2014, GAIN received US $294 million, of which the US $251 million were donated by BMGF (www.gainhealth.org).

Consequently, funding for research and development of technology-centred farming techniques has become a major part of BMGF grantmaking (Martens & Seitz,2015). Now seeds are genetically modified and BMGF has privatised seed production in Africa. There is growing criticism over BMGF that the foundation's intervention is a neo-colonial plan to make African farmers dependent on capitalists' plans (Food First, 2015; Seed Freedom, 2015).

Giant Philanthro-capitalists and Modern Philanthropy

The history of modern philanthropy was closely associated with oil giant John D Rockefeller (JDR) and steel industrialist Andrew Carnegie at the beginning of the 20th century. These business giants hailed from America and established their organisation in the field of philanthropy. The pioneer was Carnegie (1835-1919), who started Carnegie Corporation of New York with a capital of $125 Million in 1911. It was the biggest single philanthropic investment ever (Martens & Seitz, 2015). Later the organisation became the leading policy think-tank and advocacy group in the USA. As per the available data, during the 100th anniversary of the foundation, the total assets were $2.5 billion and provided grants worth $1.4 billion (MacDonald, 2013). The foundation's revenue was $253 million in 2018 and the total endowment was $3.5 billion. In the 1990s, during his 60s, Carnegie sold most of his empire worth $140 million to JP Morgan. Carnegie Foundation focuses on the promotion of education and international peace. They have been working in India since 2016 for peace promotion.

William Carnegie, his father, was a Scottish leader and part of a local movement working to better the labour class that influenced Andrew's later life. The foundation supported left organisations, feminist movements, organisations combating climate change and

immigrants. Andrew had spent the early days of childhood in libraries for his study and hence the foundation focused on building public libraries. It spent more than $55 million for building 2500 libraries in the English-speaking world. In 1889 he stated that 'the man who dies thus rich dies disgraced' (*ibid.*). He was considered the pioneer of "scientific philanthropy". He says that wealthy people channel their fortunes to the social good through systematic investment rather than the unorganised form of earlier charity (Birn, 2014). There were strong allegations against Carnegie Corporation for shielding their income from taxation during the period (Martens & Seitz, 2015).

Secondly, Rockefeller found fortune in the oil industry; the company was named Standard Oil Company. The US Supreme Court ruled that the company was an "illegal monopoly" in 1911 and ordered it to break up into smaller factions. The Rockefeller Foundation (RF) was established in 1913 in the field of philanthropy after the dissolution. The then richest man in the world, John D Rockefeller, was the founder and primary shareholder of the company (*ibid*.). The estimated asset of the foundation was $4.3 billion in 2018. It was placed at 26th position in the U.S. Unlike Carnegie's funding for charity works, JDR started investing in medical research, population control and agricultural production. The foundation focused on public health during the initial days, an emerging field in the United States. RF succeeded to create public support against hookworm disease, which was presented as the obstacle to industrialisation and cause of economic backwardness in the south U.S. The perceived success in combating hookworm disease helped establish an International Health Board (IHB) under the foundation. Later, the board spent billions of dollars to fight against other vector-borne diseases during the first decades of the 20th century and RF officers stationed in different countries around the world, including India (Birn, 2014).

The cost of healthcare in the US had increased steadily from 1930 onwards. There was a demand within the government to cut short expenditure from the social sector and invest in a productive area to decrease federal expenditure. The Committee on the Cost of Medical Care (CCMC) was set up to study the redistribution of the cost (Jahiel, 1998). It was funded by eight giant philanthropic organisations, including Rockefeller (Hall, 2006). The foundation also funded in agriculture sector for hybridising crops and technology-driven green revolution for larger agricultural product output. The RF-backed researchers succeeded in developing hybrid wheat seeds in Mexico and later, it was replicated in Chile, Colombia, and India. However, RF

gradually withdrew from these projects after many environmentalists raised concerns about the effect of hybridisation on the environment (influence watch, 2019).

When World Health Organisation was established in 1948, RF's IHB stopped functioning though the principles and legacy of public health continued through agenda setting, budget incentives, and technological support. The foundation played an instrumental role in promoting selective primary healthcare in the place of primary healthcare (Birn, 2014). Later, Rockefeller Foundation was replaced by Gates Foundation in the 21st century.

Bill and Melinda Gates Foundation (BMGF) is the largest philanthro-capitalist multinational foundation globally. Its headquarters in the United States of America holds $46.8 billion in assets as of 2019. They engage primarily in global health, agriculture, education and poverty eradication. The world's richest person for many consecutive years, Bill Gates established BMGF. He is one of the three trustees of the foundation and the founder of Microsoft, the most profitable IT business globally. Gates entered the world of charity by forming BMGF in 2000. The other two trustees of the foundation are Melinda, wife of Bill Gates and Warren Buffet. BMGF contributes 60 per cent of its grants to global health development and it has surpassed the annual budget of the WHO for several years. In 2015, Gates Foundation contributed 11 per cent of the WHO budget, which is 14 times greater than the UK's contribution. BMGF has reached more than 100 countries through different agencies and 1,100 staff.

BMGF is also a member of many international influential bodies like the Global Alliance for Vaccines and Immunisation (GAVI). BMGF is one of the four permanent board members and WHO, World Bank and UNICEF (Curtis, 2016). They contributed $750 million to GAVI in 1999 for purchasing new vaccines and another $750 million in 2005 for operational support. Global Fund (GF) to Fight HIV/AIDS, Tuberculosis and Malaria is another international body to which BMGF contributes and it also shares the board membership with them. The BMGF is also a board member of H8 (Health-8), an umbrella of eight organisations working for global health. It includes UNICEF, United Nations Population Fund (UNFPA), WHO, Global Fund to Fight AIDS, TB & Malaria (GFATM), World Bank and GAVI. BMGF established Alliance for a Green Revolution in Africa (AGRA), which stands for biotechnology-based agricultural innovation with genetically modified (GM) seeds. In short, a single family-owned foundation becomes the "most influential voice in global health" (BBC, 2013) and "most powerful word in agriculture" (The Guardian, 2012).

Three trustees from the Gates family govern BMGF without any accountability to the public and no transparency. The foundation has been under many criticisms that claimed it was trying to derail the US public education system and was making financial benefits by implementing Microsoft technology in the US education system (Layton, 2014 and Mangan, 2013). Gates' primary wealth source is Microsoft and he is the largest shareholder of the company. Microsoft is under constant criticism for tax evasion and it is reported that more than $4 billion tax is lost to the US Treasury every year, which was equal to the annual global spending of BMGF (Curtis, 2016). Scholars point out that BMGF influences the World Health Organisation (WHO) and the United Nations over policy matters (Aneja, 2016; McGoey, 2012), discussed in the coming part. Another criticism is that the foundation accumulates wealth from big charities and Gates' personal wealth has been increasing on an average of $6 billion annually even after the giving pledge (Curtis, 2016).

Philanthro-capitalists and Growing Influence on Health and Cross-border Affair

Around the world, countries began curtailing the investment in social sector development during the last three decades. It was 'inadequately' filled by international financial institutions, nongovernmental actors and private sectors (Aneja, 2016; Qadeer & Baru, 2016). While welcoming international agencies and public-private partnerships (PPP) to the social sector, the claim was that it would help eliminate inequality in access and make the public system more effective. However, the perpetrators of the PPP and other reforms understand today that the depth of inequality increased over this period and the marginalised sections became more vulnerable than before. At the same time, international funding agencies began intervening in global and national health policies worldwide (Aneja, 2016; McGoey, 2014; The Economic Times, 2014). The Gates Foundation is the world's largest donor on global health, whose share is bigger than that of the WHOs (McGoey, 2014).

In 2008, the former head of the WHO accused BMGF of lobbying and influencing the policy process of WHO (Aneja, 2016; McGoey, 2012). One of the global health scholars, Laurie Garret, says 'no policy decisions in WHO was taken without being "casually unofficially vetted by Gates Foundation staff" (cited in McGoey, 2014). Ten per cent of the World Health Organisation's overall budget is donated by a single donor that is BMGF. The same donor contributes to the United Nations' health agency more than the United States government and in 2013, it was the single largest donor to the UN. The transparency and accountability and, as reported the chance of lobbying is a major concern. Apart from this,

various research institutions that focus on global health and many opinion formers received millions of dollars from Gates' Foundation. The donor organisations also provide grants to bigger NGOs to lobby governments in favour of the donors (Global Health Watch [GHW], 2009). The Commission on Industrial Relations, US forecasted the possible danger due to the 'scientific philanthropy'. The commission cautioned about the concentration of power and wealth accumulation in the service of their capitalist ideology (*ibid.*).

> *"Recently, it (BMGF) announced a Ministerial Leadership Initiative aimed at funding technical assistance to developing-country ministries of health. The extensive financial influence of the Foundation across such a wide spectrum of global health stakeholders would not necessarily be a problem if the Foundation was a passive funder. But it is not. It is an active funder. Very active and very involved, according to many people".*
>
> (*ibid.* p. 251)

India is one of the largest medicine markets in the world. Agencies like BMGF and Ford Foundation marketed foreign medicines in the Indian medical industry (Puliyel, 2016). BMGF has a strong influence in Indian Health Ministry and Ford Foundation also has a considerable hold in the ministry (Nalpat, 2016). In 2014 alone, BMGF had given 178 crores to Indian NGOs and had provided funds to controversial fact-finding committees for lobbying (Nalapat, 2016; The Economic Times, 2014). There is evidence of the growing influence of philanthro-capitalists organisations in Indian health programmes (Aneja, 2016; Puliyel, 2016; Nalapat, 2016, The Economic Times, 2014).

One of the major concerns of these private actors is the weakening of public sector services and the eroding government spending on health and education (McGoey, 2012). The experts point out that the philanthro-capitalists organisations can withdraw their investment or related activities at any time without answering to the public except their trustees. However, the elected government has to be accountable to constitutional bodies and citizens of the country. The case of public education in the United States is the best example of this kind. Big foundations donate to premier institutes to foothold in the higher education sector. These institutes are already sufficiently funded universities, including Oxford, Berkeley, Yale and Harvard. They also grant scholarships to create intellectual elite favouring such foundations and give funds to influence research programmes (Plank, 2017). The capitalists never acknowledge labours' rights and repress workers' demands. The Carnegie Foundation had

engaged in anti-labour amendments in 1892, which resulted in a labour strike. The founder sought the help of the US National Security Guard to repress the strike and defeat the labourers who were forced back to work (McGoey, 2012).

The philanthro-capitalists augment their wealth through business strategies, sometimes criticised due to the illegal activities that they have indulged in the past. Giant organisations like Rockefeller and BMGF face criminal lawsuits over financial fraud, bribery and price-fixing. Rockefeller is also accused of corporate espionage and the creation of bogus companies to conceal illegal activities. The US Department of Justice's fact-finding report filed an antitrust case against Microsoft. The fortune was amassed through 'ill-gotten means' (McGoey, 2015). There are objections and ambiguity over how they accumulate a vast amount of wealth.

Chapter 3

Historical Development of Philanthropic and Public Institutions in Kerala

Philanthropy is an organised effort to improve the well-being of individuals and society. It is comparatively a modern term that has been used instead of charity. In ancient periods, philanthropy was practised based on the teachings of religious leaders like Buddha. During the Buddha period, monks -the disciple of Buddha- were engaged to care lepers (Johann, 2012). Lepers were bathed and fed by these monks. There was no institutionalised way of philanthropy at that time. Wherever these monks reached to preach Buddhist ideology, they did charity services there (Nundy, 2009; Johann, 2012). Most of their works were monastery centred and hence the religious centre became a charity hub. Emperor Asoka (3rd century BCE) had built hospitals and these came to be considered charity centres (Johann, 2012). Chinese travellers like *Fa-Hien* (5th century CE) and *Huien-Tsang* (7th century) have recorded hospitals and shelter homes such as '*punyasala', 'vihar'* or *'Dharamsala'* in those periods. These were not wholly funded by rulers but were run by the public giving like '*Dhana'* (Nundy, 2009). A hospital was a multipurpose centre; care receivers were provided with care and medicines. In the case of nomadic or homeless, it was a shelter, a roof over their heads, travellers stayed at night free of cost. There was no compulsion to pay and those willing to pay would have donated their share. This '*punyasala'* is somewhat similar to almshouses seen in western countries. Physicians were also available for treatment with the limited facility (Nundy, 2009 and Johann, 2012). In the Mughal period, Ayurveda *Tibb* (doctors) were also present in imperial residences and palaces. The rulers paid the Hakims and *Tibb*. However, their pupils were imparted to extend services to the needy at the spot. Their voluntary services had been either paid or delivered free of cost. At the same time, some wealthy people were ready to pay for the cure. The donations were called "*madad e ma-ash"* (hand for livelihood) (Rezavi, 2001; Nundy, 2009). The private practice emerged during the Mughal period and quacks were active in marketplaces. Private practitioners were known as *Bazare Tibb,* who set up clinics in the market side (Rezavi, 2001). Philanthropic activities in India boomed when the British established their political dominance over India for economic purposes. In India, the charity was rooted in social status, recognition, and power, especially among the wealthy. British missionaries were ahead of Indians in providing healthcare charities among vulnerable groups. Health care delivery was restricted to the army in the early days though later, the British

established medical colleges in Calcutta, Madras, Bombay and Karachi (Hinnels et al., 2007; Nundy, 2009).

The industrial revolution brought significant shifts in philanthropic activity (Marco, 1994; Weindling, 1991 and Jenkins, 2011). After the industrial revolution, the first significant change was that the religious backed philanthropy had gradually been seized by market-driven individuals and companies that could be considered secular (Weindling, 1991; Marco, 1994). The industry had set various insurance schemes for its workers and a professional touch had experimented in philanthropy. It was not a matter of concern to the States whether religious or private firms were triggered in welfare. The States encouraged both simultaneously and continued its abstinence to increase budget allocation (Doyal et al., 1999). In the pre-industrial period, the target population was mainly poor and the sick, but the revolution caused extensive urban migration in American states. Hence 'migrant labours' became the core target group of philanthropy, at least for a particular span (Hall, 2006).

Similarly, concentration came into existence as the poor and the sick were kept in different settings, communicable disease and terminal illness had been given individual attention from each other, widows, children, aged and women also took place in the 19th century (Weindling, 1991). However, some factors which promoted philanthropic activities were poverty, famine, epidemics, migration and economic growth. On the donor's side, it was religious piousness, paternalism, social status and the establishment of control (Cavallo, 1991).

In the post-revolution period, significant changes occurred to the concept of health and wellbeing. Similarly, modern medicine was more advanced (Nundy, 2009). The importance of socio-economic factors in health was widely discussed and acknowledged after long debates (Raphael, 2006). In the public health context, neither private nor philanthropic sectors can fulfil the health needs of people. However, State actions are essential and are demanded widely (Kethineni, 1991).

Similarly, another instance happened that proved the importance of the state's role in providing health care services to all. During the Great Depression of the 1930s, philanthropic funding decreased severely. Hence, many such institutions were locked down, and some were nationalised (Nundy, 2009). Philadelphia Alms House is an excellent example of the transformation explained by Rosenberg in his study (1992). It was started as a philanthropic institution later nationalised as a general hospital (Cited in Nundy, 2009). Many other examples

show that the economic recession influenced philanthropic activities to a great extent (Cavallo, 1991).

The emergence of big shots was seen and influenced governments in the first half of the 20th century. Rockefeller was one among them. The cost of care had increased steadily from 1930 onwards in the US (Jahiel, 1998; Hall, 2006).

Philanthropic Organisations in Pre-modern Kerala and Its Transformation

Kerala, a southern state in India, has been noticed internationally for its social development from the 1970s (Ratcliffe, 1977; Kabir & Krisnan, 1996; Veron, 2001). Philanthropy in the state has a due share in disseminating education and promoting healthcare to achieve development. The caste practice was dominant in the pre-modern society of Kerala. The status of an individual is determined by the caste in which they are born. Those who belong to the upper ladder of the social hierarchy discriminatorily hold resources and privileges. Due to the caste practice, large sections of the society became more vulnerable and it left them at the fringes of the state's socio-economic development (Jeffrey, 1976; Veron, 2001; Devika, 2010). Fifty per cent of the Kerala population, that is, people belonging to the oppressed castes, were denied entry into schools, health centres, temples and even public places (Jeffrey, 1976; Kabir & Krisnan, 1996; Osella & Osella, 2001). The schools and health centres run by Christian missionaries gave vulnerable people space. They were the only resort to vulnerable people to get educated and were also approached for health care (Jeffrey, 1976; Kabir & Krisnan, 1996). Several similar incidents can be traced from history.

The smallpox vaccination was initiated as early as the 19th century. All inoculators were from the ‘upper caste’ in the Travancore region and objected to vaccinating ‘lower castes’ people (Jeffrey, 1976). In Malabar, inoculators were from the ‘lower castes’. Thus ‘upper caste’ refused to be vaccinated. The issue was tackled by appointing *Pulaya* (considered as lower caste) community and Muslims in the public vaccination programme (Jeffrey, 1976; Kabir & Krisnan, 1991; Osella & Osella, 2001). During the late 19th century, it was reported that some malaria patients from the *Pulaya* community were denied medical care in a public hospital. The medicine was thrown at them to avoid close contact and pollution due to untouchability (Kabir & Krisnan, 1991). These practices were freely entertained even after the Royal Proclamation in1837, which declared that all people should be granted access to a public place without any barrier. During the 1890s and in the early 1904 and 1920s, Cholera and Malaria outbreaks were reported in Travancore and there was a loss of more than 18,000 lives (Kabir

& Krisnan, 1991; Osella & Osella, 2001; Kabir, 2003). Geographical factors like water-locked surroundings were the major cause of the outbreak. At the same time, Christian missionaries had done a good job among the expelled population to control the outbreak (Kabir, 2003). The Christian missionaries widely opened schools and health centres for deprived people by the aegis of the British government. Christian missionaries like the London Missionary Society (LMS) and Church Missionary Society (CMS) started schools, health centres and welcomed all regardless of their caste. LMS had started South Travancore Medical Mission (STMM) in the mid-19th century itself and later ten more hospitals and eight dispensaries got launched under STMM. Initially, they concentrated in the Travancore region and the Maharaja had offered support in the form of land and building.

The 19th century had witnessed the rise of the middle-class, who took significant advantage of the new land amendment made by the British and began to move upwards by achieving education and administrative positions (Panikkar, 1978). In the early decades of the 20th century, vulnerable sections of the society who were denied education and free movement had collectively protested for a dignified life. The movements later transformed into different social organisations like Sree Narayana Dharma Paripalana Yogam (SNDP) and Nayar Service Society (NSS). These are some of the organisations in Kerala which later formed their educational institutions.

The oil giant Rockefeller came to Travancore on the request made by the Travancore government to curb hookworm disease in the 1920s (Kabir, 2003). They surveyed in 1928 and the foundation was much impressed about the literacy rate in Travancore and better coverage of healthcare institutions. Despite the concern over the consecutive outbreak in Travancore, the Rockefeller Foundation had an eye on 'political and financial benefits for the United States (Ibid.). However, Rockefeller had invested time and effort as a philanthropic organisation in a small place like Kerala soon after the foundation came into existence. It must be appreciated that the foundation's involvement to control epidemics made a steady advance in public health actions like sewage construction, building up of health centre infrastructure, destruction of vector habitats by the government under the instruction of the foundation from 1930 onwards. Their entry had contributed to developing systematic and organised philanthropy in Kerala.

Southern Kerala had been more advanced in the case of infrastructure development as compared to Northern Kerala right from the pre-modern times for many reasons (Kabir & Krisnan, 1996). The Travancore Maharajas had made a treaty with the British administration

and continued power in the south, which helped regional development. Another reason was the people of Travancore, who organised and protested for their right to education and political representation. While in Malabar, the British were in power and there were constant battles between people and the British Government (*ibid.*). As a result, education attainment was given the least importance by the people. Charity organisations had entered the Malabar region in the later stage of the 20th century. It also delayed the development of the region. North-South regional inequity in socio-economic development continues to date (Jacob, 2014).

North-South Divide and Development Disparity

The development of philanthropy in the Malabar region was almost stagnant until the 20th century. An organisation named Basel Evangelical Mission (BEM) had started a hospital close to 1900. The Muslim groups started orphanages to overcome damages in the political conflict with the British in 1921. They concentrated on the education of orphans from the Muslim community and actively participated in an epidemic control during the 60s. In the latter half of the 20th century, philanthropic and private institutions emerged slowly without adequate healthcare services in the public sector. Their growth was intensive during the 1990s (Dileep, 2008). For many years, it has been a public decry that the governments' liberal stance over self-financed institutions (philanthropic and private) is a major reason for declining the public services (*ibid*.), which needs to be studied more.

However, the religion and caste-based philanthropic institutions transformed the post-90s in line with global and regional changes. A recent study reveals (Sajid, 2015) that these institutions started serving the middle and upper-class sections instead of the needy people. The smaller organisations in the state were transformed into bigger and began to concentrate on medical education with techno-centric care (Dilip, 2008). The institutions in Kerala concentrated on urban locations and developed markets like many other philanthropic institutions in the world. The reasons behind the transformation of philanthropic organisations are identified in these ways. In the post-90s, newly emerged private health care centres in Kerala created a competitive market situation. The institutions faced the question of 'survival' and started user charges, welcoming investments from the Gulf-migrated Malayalee industrialists. Finally, the Government of Kerala legitimised the opening of self-financed (including philanthropic) institutions in the medical and education sectors, which attracted more investors (Sajid, 2015). There were only five government medical colleges in the state during 1994-2007. On the other hand, 13 self-financed medical colleges, five Ayurvedic

medical colleges, 13 dental colleges and two homoeopathic colleges were started within the same period (Dilip, 2008).

The features of philanthro-capitalism and philanthropic institutions in Kerala are not thoroughly documented yet. It represents the giant capitalist foundations around the world. At the same time, the trait held by philanthro-capitalists is comparable to the religion and caste-based organisations working in the health sector of Kerala.

The critics draw "profit augmentation" as the trait of philanthro-capitalist foundations along with "strategic investing" and growing influence over government (Rogers, 2011). The masculine attribute (Jenkins, 2011, Ramdas, 2011) of philanthropy is also evident everywhere. The wealth and activities of philanthro-capitalist organisations largely revolve around developed countries or regions other than low-income or poor regions (McGoey et al., 2009). Based on a former analysis, the proposed study argues that the institutions in Kerala accumulated a vast amount of assets over the periods. Their investments are concentrated in the healthcare and education sectors, but they also have shares in profit-oriented businesses. The shield of philanthropy, religion and caste identities legitimate their commoditisation of healthcare and education in the market. The three characteristics that are 'philanthropy, religion and caste' facilitate them to influence the government, public policy and people in interaction with them to expand the industry.

Growth of Philanthropic Organisations after 1990

The religion and caste-based philanthropic organisations in Kerala were transformed after the 1980s. There was a steep boom in the number of organisations after the 90s. Earlier, the institutions concentrated on healthcare services. Later medical education institutions were added to these and hospitals cum medical education services fused into a single institution. As a result, these institutions grew in number. The growing number of organisations had a regional concentration to the southern part of the state, which is more developed in the case of public institutions (Table-3.1).

Table-3.1 shows district-wise philanthropic organisations in various decades from 1950. The organisations that worked for either the health or education sector eventually consolidated both sectors into a single organisation. In the 1950-60 decade, three important philanthropic organisations were established exclusively for healthcare services, seven for education and 16 for both education and healthcare in Kerala. All three organisations that

worked for healthcare were geographically concentrated in the southern districts. Out of the sixteen organisations that worked for the healthcare and education sectors, 13 were concentrated in the southern region. This dominance continues over the decades and North Kerala is under-represented.

Table-3. 1 District Wise Selected Philanthropic Institutions in Different Decades

District	Year of Inception					
	1950-60	60-70	70-80	80-90	90-2000	00-2010
Tiruvananthapuram	1(E) 2(B)	1(E) 1(B)	1(E) 2(B)	1(E) 1(B)	1(H) 1(E) 6(B)	10(B)
Kollam	3(B)	0	1(B)	2(B)	1(B)	1(B)
Pathanamthitta	1,(H) 2(E) 1(B)	0	1(B)	1(E)	1(H) 1(B)	1(H) 1(E)
Alappuzha	0	1(H) 1(B)	1 (H)	2 (H)	2(B)	0
Kottayam	2(H) 1(E) 1(B)	2(H)	0	3(H) 2(E) 2(B)	2(H) 1(E) 3(B)	2(H) 1(E) 2(B)
Idukki	0	0	1(H) 1(E) 2(B)	1(H) 1(B)	0	0
Ernakulam	3(B)	1(E) 1(B)	2(B)	1(H) 1(E) 1(B)	1(H) 1(B)	1(E) 6(B)
Trissur	3(B)	1(B)	1(B)	1(E) 1(B)	1(H) 1(E) 2(B)	0
Palakkad	0	0	0	2(H) 1(E)	2(B)	3(B)
Malappuram	1(E) 1(B)	1(E)	1(E)	1(E) 2(B)	3(E) 1(B)	1(E)
Kozhikode	2(B)	2(E) 1(B)	1(E)	1(B)	1(E) 1(B)	2(E) 3(B)
Wayanad	0	0	1(E)	1(H)	0	2(E)
Kannoor	1(E)	0	0	1(E)	0	0
Kasaragode	1(E)	0	0	1(B)	1(E) 2(B)	0
TOTAL	3(H) 7(E) 16(B)	3(H) 5(E) 5(B)	2(H) 5(E) 9(B)	10(H) 9(E) 12(B)	6(H) 8(E) 22(B)	3(H) 8(E) 25(B)

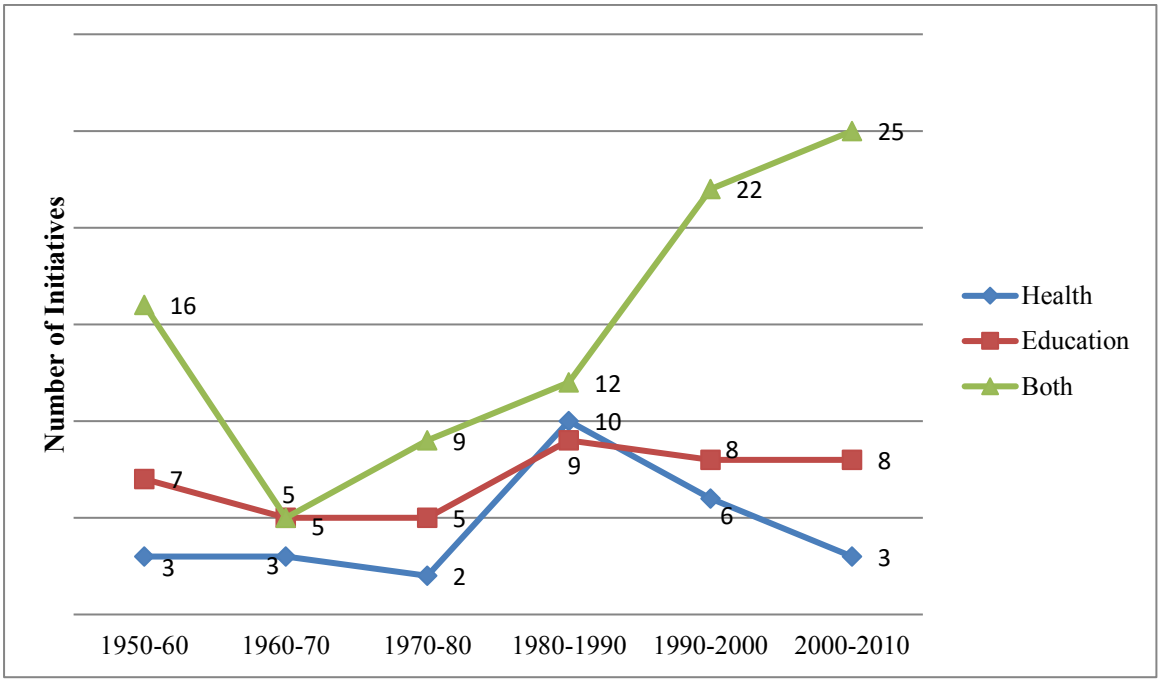
Note: H-Health E-Education B-Both Health & Education (Darkened bottom part is Northern Kerala/Malabar)
Source: GOI 2014 http://ngo.india.gov.in/state_ngolist_ngo.php

(Source: Sajid, 2015)

In the 1980s, there was a sudden boom in overall philanthropic organisations, especially in the health care sector, compared to the earlier decades. Three healthcare institutions in the 1950s had increased up to ten by the 1980s. In the 1990s, it declined to six, but organisations concentrated in both sectors increased by 22 from 12 and ended at 25 by 2010 (Table-3.1). We can conclude with an assumption that a steady boom in the number of organisations after 1990 indicates that these organisations shifted concentration from exclusive health care to medical education and healthcare simultaneously. Districts like Thiruvananthapuram (TVM), Ernakulam (ERS), Thrissur (TRS) and Kottayam (KYM) from the south have the highest number of organisations most of them deal with education and health care. While considering the northern region, most of the organisations are concentrated in Kozhikode (KKD) (Table-3.1). In this, organisations working exclusively for health or education and health care are very few in the Northern region. One can wonder how these philanthropic organisations could be concentrated in urban or semi-urban districts of Kerala. They are supposed to serve humanity regardless of the rural-urban differences. Ernakulam, Thiruvananthapuram and Kozhikode districts are packed with needy services like health care and education. Other districts like

Malappuram (MLP), Wayanad (WYND) and Kasaragode (KSD) from North Kerala and Idukki (IDK) from South Kerala are least served by public and philanthropic institutions (Figure-3.1).

Figure-3. 1 Growth of Philanthropic Organisations in Various Decades based on their Working Area in Kerala



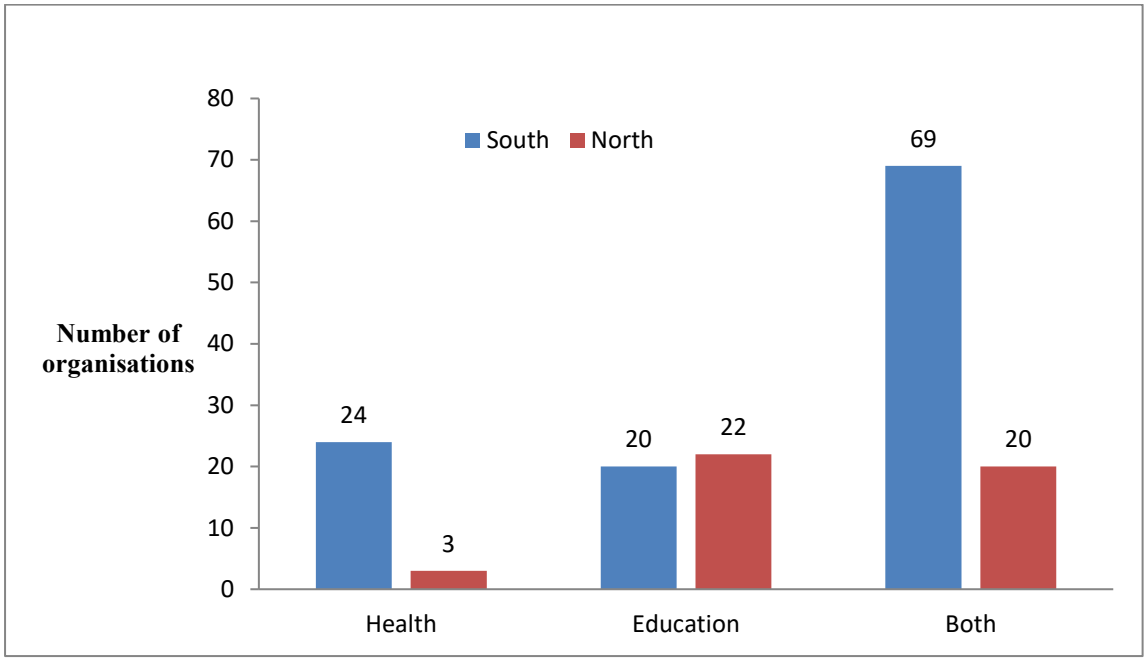
Source: Sajid, 2015

On the other hand, Gulf migration from Malabar has helped an economic investment and subsequent development in the Malabar region (Azeez, 2009; Zachariah et al., 2012). Osella & Osella (2009) write, 'most Muslim migrants think of their fellow beings and were motivated by religious piousness, recognised as concerned persons on the backwardness of the respective community and actively engaged in community development. Educated middle-class migrants of the Malabar region had started supporting educational activities like providing scholarships and establishing colleges in the backward regions (Sajid, 2015). They became the key investors in these developments.

Table-3.1 shows another important concern: the institutions concentrate in the south rather than the north, where public institutions are less. The northern region consists of only three institutions that render health care, while in South Kerala, it is 24. The northern region has a slightly higher number of institutions (22) than 20 in South Kerala in the education sector. However, a major disparity is seen in both sectors in which the Southern region has 69

institutions against 20 in northern districts, which is more than three times higher in 2015 (Figure-3.2).

Figure-3. 2 Regional Concentration of Philanthropic Organisations in North and South Kerala Based on the Working Area in 2015



Source: Sajid, 2015

However, these organisations have undergone transformation where poor people faced issues in accessibility and affordability of the services. The utilisation of free beds in philanthropic hospitals has gone down. The philanthropic organisations have augmented considerable assets in the last three decades. They moved to concentrate on profit augmentation and the discrepancy between private and philanthropic institutions have been blurred. These changes were considered an outcome of the scarcity of public institutions in the northern region. The scarcity resulted in the steady growth of organisations.

History Reconstructed to Understand Institutionalisation of the Charisma

Philanthropic institutions in Kerala from three locations will endorse the study. The female spiritual leader is popularly known as 'Mother' known internationally and her Mission is hailed from Kollam, a southern district of Kerala. It was registered in 1988; the new venture is active in India's education, healthcare, and rehabilitation. The Mission has more than 60 schools, engineering colleges and a modern tertiary-care medical college in Kerala. It runs a

university, one of the biggest ventures spread across five campuses in three south Indian states. The 'ashram' also manages 40 temples in different places of the state.

The global base of her devotees considers 'Mother' as a 'hugging saint' with supernatural abilities. She explains that 'it is a spiritual awakening rather than a hug' and as per the claim of her website, she hugged 36 million devotees till 2019. The devotees are political leaders, including the Prime Minister of India, film actors, Nobel laureates and other influential people. She spends fourteen to sixteen hours at a single stretch in a day for the 'spiritual hug', which is live-streamed through her T.V channel. She manages a global NGO, which is also a consultant to the United Nations.

Biography with a combination of myths is a source of analysis on the construction of a charismatic persona. 'Mother' is from a traditional Hindu family who lived in Alappad, a coastal area in the Kollam district. She belongs to the Araya community, which is considered a 'lower' caste in the caste system and their occupation is fishing. However, she has a wide range of devotees from different castes and they are in 'close contact' with her without the barrier of caste pollution. She was born as 'Sudha' in 1953 and it was believed that she was the manifestation of Krisna. The website provides her biographical details as 'she was born smiling with dark blue complexion'. She started walking at six months and her supernatural manifestations continued in childhood while she was entitled as Devi. The biography is filled with the notion of 'suffering', which is a significant contributor to the construction of charisma (Najeeb, 2014).

In the late 1970s, the institutionalisation of her charisma was taken place. She was hailed as 'Mother' when she opened an Ashram in 1980 and she was 'formally given' the name Devi. In 1981, the Mission was registered officially and started functioning in the Kollam district. The growth of Mission using religion needs to be analysed in a sociological way keeping the socio-political conditions of Kerala in mind. The state-religion-corporate mix fuels growth of philanthro-capitalism and it becomes a superpower and gets deeper influence in the 'secular' public life.

The Institutionalisation of a Civic Organisation

Another example of the transformation of philanthropic organisations is a trust from Kozhikode district in north Kerala (Malabar). It was registered under Societies Registration Act-1860 in Kozhikode in 1964 with the support of professionals and NRI business people.

The trust concentrated only in the education sector. The Founder of the trust belongs to a middle-class family. He completed medical education from the UK and became a renowned cardiologist in Malabar. During that time, middle-class Keralites have given overwhelming importance to education and the focused community was in dire need of educational assistance. They provided scholarships for bright students for achieving higher studies. They claim that scholarships worth Rs. 2 million per annum have been provided for brilliant students from vulnerable groups. Within a short span, the trust started arts colleges. The trust started the first self-financing engineering college with minority status in Kerala. The trust has Youth and Women wings all over Kerala and the Middle East. In 2003 their dream project, a medical college, come true.

As per the details on the organisation's website, the medical college is a *"multidisciplinary medico network"* located in Perinthalmanna Taluk run by a trust. The Taluk is the *"hospital hub"* in Malappuram district, a rural hilly area well connected to roads and transport services even if it is remotely located. However, the location is identified as one of the places where rapid urbanisation occurs. The network includes medical college, teaching hospital, dental and nursing colleges. National and state statutory bodies recognise it. Altogether 200 seats are there for MBBS, dental and nursing colleges. It has achieved the award for academic excellence and produced top rank results in medical examinations. The institution is spread across 60 acres of land and several buildings for educational institutions, hospitals and hostels for the students are comprised in the area. The hospital is a four-storied building with more than 20,000 sq m area and 500 beds capacity.

The chairman of the trust is a UAE settled migrant. The present director of the institution is a general physician, son of the then director. Governing body is elected through voting and has three years of tenure. There is no limitation in contesting for a post. Voting power is vested to eighteen members of the governing body. There are two types of memberships. One is ordinary membership in which anyone can be an ordinary member of the trust by paying Rs100 as a registration fee. Golden membership is reserved for those who have completed particular years and produce considerable subscriptions for the trust. The trust has more than 11,000 members, including ordinary and golden members all over Kerala and Middle East countries. Their subscription is a primary source of income. In the 1970s, within ten years after its inception, the trust launched schools in the Middle East focusing on NRI families. Now there are 15 schools managed by the trust in various Arab countries. The trust has more than 11,000 members and 150 institutions, including CBSE schools, arts and

engineering colleges, apart from the medical college. Women's wing of the trust runs a college for women in the Calicut district. It has assets worth 150 billion Indian rupees spread across India and Gulf countries.

The migrated entrepreneurs from Malabar have adopted practices of global capitalism much earlier and have been considered the social innovators for liberalising the Kerala economy (Osella & Osella, 2009). Their recognition as community leaders on account of the 'concern' on the backwardness of the respective community and associated toil for the development. The community leaders' involvement in managing orphanages, administration of schools and political activity are the elements of developing a community.

Human Welfare and Evangelism of 'Gospel'

The third institution is a Christian evangelical venture of the largest mission organisation, 'Gospel,' which spreads across 13 countries. The website says it was founded in 1978 to evangelise India and Asian countries. It is considered one of the most influential missionary movements in the world, led by 'Yohan' from Kerala. He had set up 'Gospel' headquarter in Thiruvalla in 1983. The church engages in healthcare, education, community services and rehabilitation programmes. Yohan, the patron, runs various community development projects. Under the said projects, the schools, engineering and medical colleges are administered at various locations in Kerala. However, the 'Church' was registered as a trust in 1993 under Indian Trust Act-1882 in Thiruvalla, Pathanamthitta district. According to the information given by the Home Ministry website, it has been one of the top four foreign fund receiving organisations in India for several years.

Development of Public Institutions in Kerala till 1996

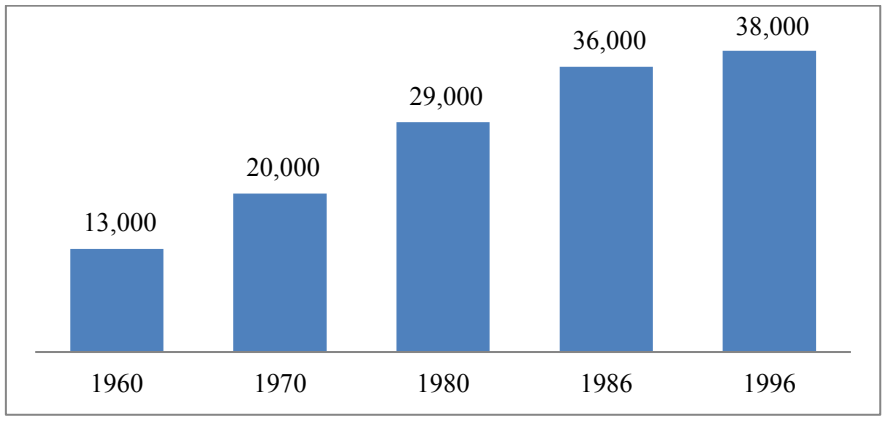
Kerala has a long history of systematic and organised healthcare structure and services. The state has proved that the constraints like lower per capita income, industrial development, and production will not impede social sector development. Before the advent of 'English' medicine, practitioners of indigenous medicine like Ayurveda were approachable to the needy. They have been practising a system of transferring traditional knowledge from generation to generation. The colonial powers established their medical system by introducing missionary hospitals and doctors from the very beginning of the invasion. The princely state rulers also took the initiative to include the western system of care in the medical education curriculum (Kabir & Krisnan, 1996). This section deals with the development of healthcare institutions in

the public sector of the state till 1996. The year 1996 is selected because there is a clear demarcation in the development of a said sector in the 1990s. The period witnessed major economic and social changes in the country and the state of Kerala.

Here, health service development includes major landmarks in the state's preventive and curative care services. In 1928, the Travancore state initiated a survey to control hookworm disease, a significant milestone in Kerala's history of public health promotion. Cochin and Trivandrum General Hospitals were constructed in the first half of the 20th century. Some hospitals in Kerala are more than 50 years old. At the time of states' formation in 1956, a robust public health system had been laid. Since then, the development of government health services has achieved remarkable development (Kutty, 2000). The proportion of state expenditure for education and health is one indicator of the government's commitment to social sector development.

Development of social sectors, comprising health and education, accounted for a significant share of the government expenditure from the state formation to the 1980s (Table-3.2). As a result, infrastructure development like healthcare institutions, hospital beds and human resources expanded from 1960 to the 1980s.

Figure-3. 3 Total Number of beds in public hospitals from 1960-1996



Source: compiled from Kutty, 2000

Bed strength is considered as one of the indicators to understand the development of the sector. In 1960, the total number of beds in public hospitals was 13,000. It was increased to 20,000 in 1970 and 29,000 in 1980. By 1986 the total beds in the public hospital were 36,000 and 38,000 in 1996. During the period of the fiscal crisis in 1980-1990, the growth stagnated

considerably, reflected in the number of beds after 1986. There was an increase of only 2000 beds in the last decade, which marked the lowest growth (Figure-3.3).

The government expenditure on health was 8.8 per cent despite the deficit reaching 5.1 in 1985-86. The revenue deficit was 10.9 in 1987-88 and 1989-90 even though the expenditure was maintained at 8.5 and 8.4 per cent respectively. In the financial year of 1990-91, the deficit was ever higher at 14.9 per cent, and expenditure on health declined to 7.9 per cent. After the fiscal crisis, the revenue deficit declined gradually. However, the average health expenditure was seven per cent and not maintained as in the previous years (Table-3.2).

Table-3. 2 State Expenditure and Revenue on Health from 1985 to 1996

Year	Total Revenue Expenditure (million Rs)	Expenditure on health (million Rs)	Health expenditure as % of total revenue expenditure	Revenue deficit as % of total revenue expenditure
1985-86	14453	1268	8.8	5.1
1986-87	16548	1451	8.8	9.2
1987-88	17807	1510	8.5	10.9
1988-89	20610	1637	7.9	8
1989-90	22931	1923	8.4	10.9
1990-91	28249	2220	7.9	14.9
1991-92	32165	2318	7.2	11.3
1992-93	36561	2392	6.5	9.2
1993-94	42934	2985	7.0	8.7
1994-95	50663	3566	7.0	7.9
1995-96	58364	4179	7.2	6.9

Source: Government of Kerala, Economic Review, 1997 cited in Kutty, 2000

"Figures show the annual compound growth rate of government health care expenditure for the period (1956-1980, author) *at 13.04%, outstripping both the annual compound growth rate of total government expenditure at 12.45% and the annual compound growth rate of the state domestic product at 9.81%."*

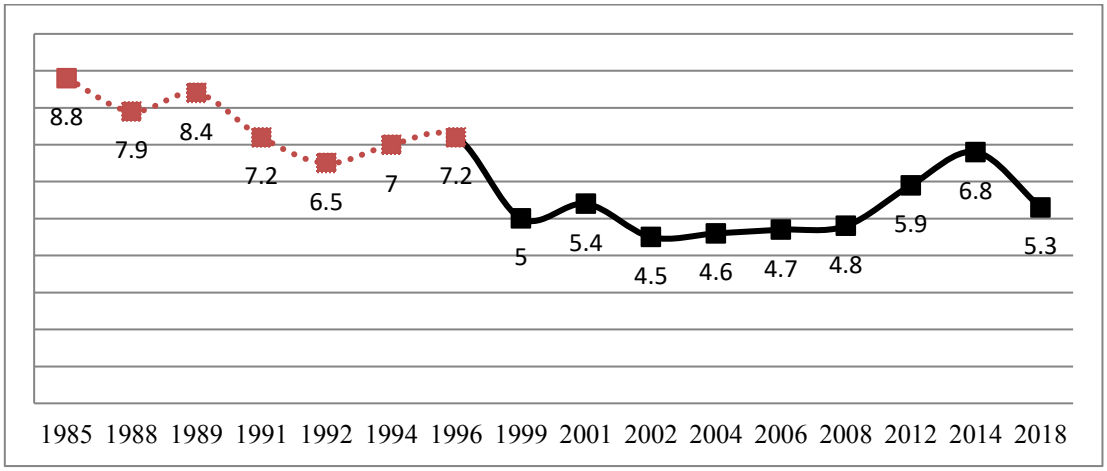
(Kutty, 2000, p.104).

Despite the proper expenditure on health during the period, it is not reflected in the structural developments of the health services (an increase of 2000 beds in a decade). It indicates that the spending on salaries and other consumables continued to grow despite the deficit while spending on buildings and infrastructure stagnated. It means that revenue expenditure like the salary of healthcare personnel has eaten away the structural developments while capital expenditure has reduced. It had a significant effect on the district and taluk hospitals and the primary health centres.

Public Health Sector Development after the Period of 'Economic Crisis' in 1990

We have seen that the successive state governments maintained the expenditure on health despite the economic crisis (Table-3.2 and Figure-3.4). It was an average of 7.5 per cent from the state formation to 1996 (the dotted line in the Figure-3.4). However, after the crisis, precisely from 1999, the average health expenditure has declined to 5.2 per cent (Figure-3.4) and as we discussed earlier, revenue expenditure is a significant part of this. In short, we can conclude that institutional development has slowdown due to the decline in budget allocation to the health sector after the economic crisis and decentralisation in 1996.

Figure-3. 4 Kerala Health Expenditure 1985-2018 (in %)



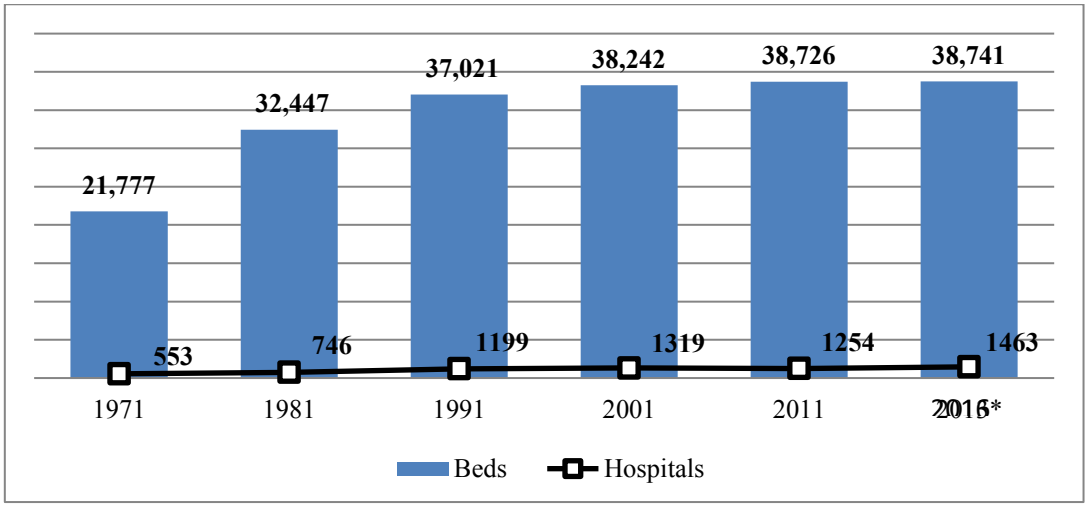
Source: Kutty, 2000; NCAER, 2015; Berman et al., 2017 and PRS India, 2019

While analysing the hospitals and number of beds from 1970 to 2016, we can understand the stagnation in the public sector development. The data given in Figure-3.5 indicates that the number of beds in public hospitals has been growing slowly for the last four decades compared to previous decades. It includes PHC CHC and other higher-level hospitals. During the initial decade of 1971-1981, the growth rate was 49 per cent and then it declined to 14 per cent in 1991. Later it was only three and one per cent in 2001 and 2011 respectively. A

study reveals that the growth in the public sector is only 5.5 per cent, whereas, in the private sector, the growth is 40 per cent (Kutty, 2000).

Similarly, the number of public hospitals doubled in the first two decades. It was 553 hospitals in the public sector in 1971, which had become 1199 in 1991. In 1981-1991 the decadal growth rate was 61 per cent, an ever time high, which grew from 35 per cent in 1971-1981. Later the rate declined to 10 per cent in 1991-2001 and showed negative growth in 2011 (Figure-3.5). It is essential to understand that the share of public hospitals has declined from 53.3 per cent in 1970 to 22.7 per cent in 1990 (Sadanandan, 2001). After the crisis period, largely due to the decline in allocation and expenditure, the growth became slowdown. As per various reports, private healthcare institutions have mushroomed during the same period in Kerala, which will be discussed in detail. The introduction of economic policies and private wealth investment in public services became a government policy that resulted in this scenario.

Figure-3. 5 Number of Beds and Hospitals in Kerala from 1971-2016

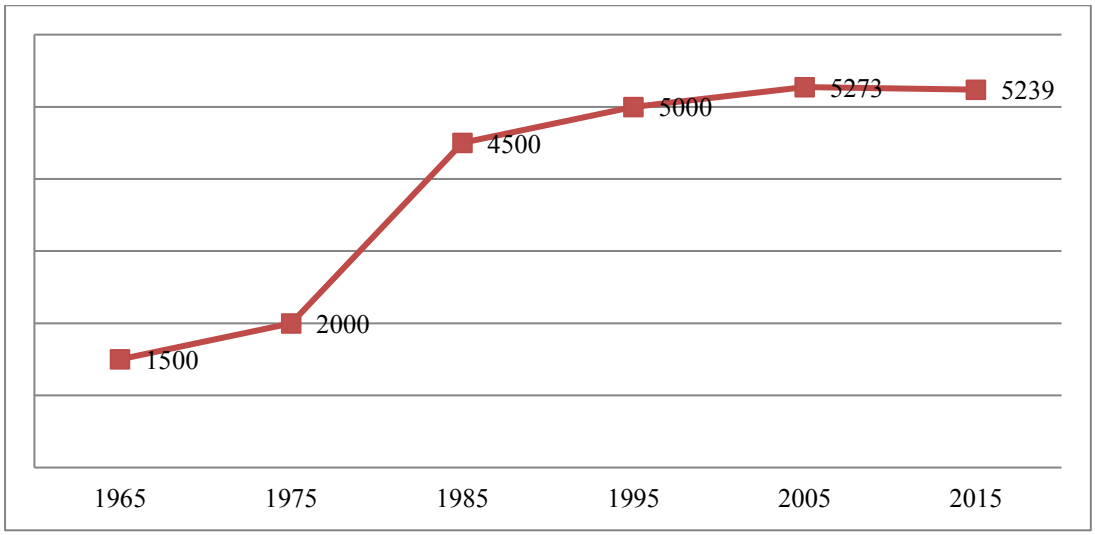


Source: Economic Review, 2016 *Director General of Health Services, 2016

Number of Doctors in the Public Sector from 1960-2016

In the case of government doctors, Kerala had a density of 3.2 doctors per 10,000 persons in 2016. The number of government doctors from 1960 to 2016 is given in the Figure-3.6 which shows the growth rate. In 1965 there were 1500 doctors, which increased to 2000 after a decade. In 1985 it became 4500, which marked a 125 per cent decadal growth rate. The number of doctors in 1995 and 2005 was 5000 and 5273 respectively. The growth was linear from 1995. There was only a five per cent increase in the number of doctors during 1995-2005 and had shown negative one per cent growth in the last decade (Figure3.6).

Figure-3. 6 Doctors in Government Sector 1960-2015



Source: Kutty, 200; Madore et al., 2018

At the same time, there are 3355 medical practitioners in Kerala registered with medical councils in 2016 alone. There were 55,251 registered doctors in the state till 2017. The private sector does not always bag them. However, a continuous 'brain drain' of trained medical practitioners developed under public expense is a serious concern in the health sector. However, it is a fact that medical practitioners in the private sector had a 63 per cent growth during 2005-2015 (Berman et al., 2017).

A shortage of 342 specialists in 2005, including gynaecologists, surgeons, physicians and paediatricians in the government sector, had not been filled. The shortage increased to 849 in 2015. Similarly, 659 technicians' and 159 pharmacists' posts were not filled in 2005. The pharmacist posts were filled in 2015, while 684 technicians' posts were vacant in 2015 (Table-3.3).

Table-3. 3 Health Resource in Government Sector in 2005 and 2015

Posts	Required	Sanctioned	Filled	Shortfall	Req. 2015	San	Filled	Short
Specialists (CHC)	424	424	82	342	888	30	39	849
Pharmacists	1017	1038	858	159	1049	1039	1102	--
Technicians	1017	368	358	659	1049	324	365	684

Source: Madore et al., 2018

Public hospitals in Kerala face resource shortages, especially physicians and technicians, so people need to depend on private clinics. However, in the case of qualified nurses, 18.5 per 10,000 persons are present in Kerala. More than 38.4 per cent of medical nurses of India are concentrated in Kerala (*ibid*.). On the other hand, the density of trained physicians in Kerala is 3.2 per 10,000 persons, lower than the national average of 3.4. The shortage in the public sector affects the functioning of secondary and tertiary facilities, specifically in CHCs. A study in 2015 shows that 91 per cent of CHCs did not have an obstetrician and a general surgeon (Rao, 2016 cites in Madore et al., 2018).

Medical Education in Kerala

Medical education in Kerala can be classified into Indian and Allopathic systems of medicines. Indian Systems of Medicine and Homeopathy (ISMH) include Ayurveda, Unani, Sidha and Homeopathy. The nursing and paramedical courses are also included in the medical education offered by private (including philanthropic) and public institutions. The density of physicians in Kerala is lower than the national average, whereas 185 nurses are available for 100,000 persons, which is six-fold higher than the national average of 32. However, 60 per cent of the total 3,000 medical graduates in Kerala are produced by private institutions per year. In the case of nursing education, there were 1,557 public and 16,043 private centres for the aspirants in 2016 (Madore et al., 2018).

There are ten government medical colleges in Kerala (Table-3.4). They are Thiruvananthapuram Medical College, Government Medical College Kollam, T.D. Medical College Alappuzha, Kottayam Medical College, Ernakulam Medical College, Government Medical College Idukki, Thrissur Medical College, Palaghat Medical College, Kozhikode Medical College and Manjeri Medical College. Besides this, there are two co-operative medical colleges also working under the supervision of the government. Government medical colleges offer altogether 1200 seats every academic year which comprises different systems of medicine. Overall, 1242 beds are available in these medical colleges (Table-3.4).

Table-3. 4 Government Medical Colleges in Kerala

Medical Colleges	Year of Establishment	Intake	Bed Capacity
Kottayam	1970	150	910
Kozhikode	1957	250	3080
Malappuram	2013	100	501
Idukki	2014	0	300
Kollam	2016	100	500
Thrissur	1981	150	2350
Palaghat	2014	100	750
Alappuzha	1963	150	1051
Trivandrum	1951	200	3000

Source: National Health Profile, 2018

Since medical education is considered to produce a higher level of income returns in the future, there is a tendency among private and philanthropic institutions to charge a fee that is much higher than the cost required to provide the education (Prasad et al., 2016).

The annual fee for medical education is of four types in Kerala, excluding the hostel and other fees; Merit-fee in government medical colleges, merit-fee in self-financed colleges, fee in management NRI quota. Merit-fee in Government College costs INR 25,000 per annum for MBBS education. The merit fee in self-financed colleges is INR 600,000 per annum, while management and NRI fee start from INR 1.4 million to INR 2 million in 2019. The difference in fees between government and self-financed colleges in medical education is because of the absence of proper regulation and lopsided private entry (*ibid*.). The increasing cost of medical education every year is justified by the cost-recovery of the revenue expenditure incurred by the self-financed colleges. However, there is no effective mechanism from the government side to estimate the cost-recovery in private, self-financed and philanthropic colleges. It creates barriers to vulnerable sections to access medical education (Kumar, 1997).

Chapter-4

Evidence from the Field: Analysis of Healthcare Services Provided by Philanthropic Institutions

Philanthro-capitalism in Healthcare and medical education: An Analysis of Situation in Kerala is a study of the rising capitalist motive in the religion and caste-based philanthropic institutions that deliver services like healthcare and medical education in the state of Kerala. Three institutions were selected for the study based on their charisma and years of experience in the field. The geographical locations of these institutions warrant observations. One is located in a semi-rural place in a taluk known to be the 'hub of hospitals' while another is from a metro city. The third institution is located in NRI city, where many migrated Keralites can be found. The transformation that took place to these locations due to the presence of hospitals is an academic exercise.

This chapter analyses the socio demographical profile of the respondents from various institutions with the help of tables and figures. It begins with a short profile of the three hospitals and an overall understanding of the institutions, explained descriptively. The evidence from the field is discussed herein in both an objective and subjective manner. The researcher interacted with a wide variety of respondents to obtain the various aspects of the functioning of these institutions. The respondents were doctors, auxiliary workers and users from each institution. MBBS, dental and nursing students from the medical colleges run by the same foundation were part of the study. The administrative officers of the trusts or hospitals also responded to the questions. The data was collected from July 2018 to January 2019. The researcher has to overcome a major constraint faced during the fieldwork: the respondents' continuity. While working in a hospital, the respondents, like healthcare workers, may leave the session after consuming our time due to an emergency. The administration, for this reason, may not entertain any interaction with healthcare workers in their duty time.

Profile of the Hospitals

The respondents from the three selected institutions vary in size and nature (Table-4.1). These three institutions represent three social identities and each has a different kind of entity. Institution-A is a medical institute affiliated with a trust located in South Kerala and managed by a Hindu spiritual leader. They engage in social development activities like disaster relief

and education, healthcare and women empowerment. The activities of the trust are spread at the international level. The second institution is a medical college hospital under a Christian mission, run by a Metropolitan from Central Kerala. Institution-B in the analysis section represents the mission strives for human development, income generation, education and healthcare in various low-income countries globally. The third one is under Muslim management from the Malabar region of Kerala. They concentrate on providing education and healthcare services chiefly to the socially and educationally backward communities. The institution spans across Kerala and Gulf countries, represented as Institution-C.

Table-4. 1 Overview of the Selected Institutions' Medical College Hospitals

Features	**Institution-A**	**Institution-B**	**Institution-C**
Land in acre	125	30	60
Sq. ft*	3.3 Million	90,000	1,50,000
Beds	1450	500	600
OT*	28	10	15
ICU*	275	25	30
Department (Major+ Other)	12 + 45	10+17	17+12
Total staff	4500+	2500	2500
Medical Education	Western, Dental, Indian systems, Nursing, Pharmacy and paramedical	Western, Nursing and Paramedical	Western Medicine, Dental, Nursing, Pharmacy and Paramedical
Students (annum)	2500	250	400
users (annum)	10L & 70K IP	30,000	70,000

Source: Data collected from the field during 2018 July-Jan 19 and updated through respective websites *Sq. ft=Square feet, OT=Operation Theatre, ICU=Intensive Care Unit

Institution A

It is working under an international charitable foundation run by a spiritual leader located in Kollam district in South Kerala. The hospital is located in the Eranakulam district and is one of the largest ventures with multi facilities in Kerala. The campus of the hospital spreads on a 125-acre of land with 3.3 million sq. ft of buildings. The bed strength of the hospital is 1450 as of 2019. It has 28 Operation Theatres (OT), almost double in size than the

other two hospitals. It is one of the leading emergency care providing hospitals in Kerala, with 275 Intensive Care Units (ICU). There are 12 significant departments with techno-centric specialities and 45 sub-departments. The total staff strength is 45,000, who serve 70,000 in-patients and 1 million outpatients annually. All the systems of medicine are taught for 2500 students (Table-4.1).

Institution-B

The trust is a Christian evangelical venture of the largest 'mission' organisation. Their website says that the mission was founded in 1978 to evangelise India and other Asian countries.

The medical college under the mission spreads over 30 acres of land, which is in the Pathanamthitta district. The Medical College Hospital provides primary and tertiary care services covering a 90,000 sq. ft building. It has a 500-bed capacity, including observational and day-care beds. The facilities for emergency care, including ten operation theatres, 35 emergency beds and 25 intensive care units, are available. There are 27 various major and minor departments functioning in the hospital. The total strength of staff is 2500 who serve 30,000 care users annually as of 2018. They also offer medical education in western medicine, the Indian system of medicine, dentistry, nursing, and lab technician courses. Two hundred fifty students graduate from these departments every year (Table-4.1).

Institution-C

Institution-C is a society that runs a"multidisciplinary medico network" started in 2003 in Perinthalmanna Taluk of Malappuram district. The Society was started in 1964 in the Calicut district with the support of professionals and NRI businesspeople.

The institution spreads across 60 acres of land and several buildings for educational institutions, hospitals and hostels for the students are comprised in the area. The hospital is a four-storied building with more than 150,000 sq. m area and 600 beds capacity with 15 operation theatres (OT) and 30 intensive care units (ICU) which provide round the clock service. It has 17 major departments and 12 minor departments. The hospital serves 70,000 in-patients and outpatients per year.

It includes medical college and teaching hospital, dental and nursing colleges. National and state statutory bodies have recognised it. Altogether 400 seats are available in MBBS,

dental and nursing colleges. It has achieved awards for academic excellence and produced top rank results in medical examinations. Four hundred students graduate from these institutions every year (Table-4.1). The organisation also runs three hospitals and clinics in different districts of Kerala.

Socio-Demographic Details of the Service Providers and Seekers of the Institutions

The researcher selected 209 respondents from various categories from each institution, including healthcare seekers, caregivers, administrators of the institutions, and medical students. Total health care seekers are 91 and 13 health caregivers, 13 administrative officers from various positions and 92 medical students responded to the study (Table-4.2). Nine case studies are also included in the category of healthcare seekers.

Table-4. 2 Overall Respondents from institutions

Respondents	**Inst. A**	**Inst. B**	**Inst. C**	**Total**
Healthcare Seekers	31	30	30	91
HC Givers	6	4	3	13
Administrative officers	5	5	3	13
Students	32	30	31	92
Cases	3	3	3	9*
Total	**74**	**69**	**67**	**209***

Source: Data collected in the fieldwork during 2018 June-Jan 19
*Cases from the healthcare seekers hence it is not added to the total

The healthcare seekers, caregivers and students were interviewed using an interview schedule. The administrative officers were interviewed through an open-ended questionnaire. Among those who responded, health seekers are 31, 30 & 30 and administrative officers are five, five and three from Institution-A B and C, respectively. Similarly, health caregivers and medical students are six, four & three and 32, 30 & 31 from the respective initiatives (Table-4.2).

Institution-A

In Institution-A male respondents constituted 64.5 per cent, nearly double the 35.5 per cent of female healthcare seekers. In the case of religion, the healthcare seekers from the Hindu religion are 68 per cent. Muslims constitute 19 per cent and Christians are three per cent of the total respondents in Institution-A.

Similarly, people with sufficient economic background constitutes 84 per cent who belong to the APL category and only 16 per cent of the total healthcare seekers in the institution belong to the BPL category. The poor economic condition of vulnerable people is a barrier to accessing tertiary-care services. Alarmingly the presence of Scheduled Caste is three per cent only. It shows that socially and economically underprivileged groups face hurdles in accessing philanthropic healthcare institutions (Table-4.3).

Two possible interpretations of this analysis are; social identities like religion and caste are influential in accessing the services from the institution. People with the same social identity as philanthropic institutions are more inclined than those with different identities. It is elaborated in the following sections while analysing the case studies.

Table-4.3 Socio-Demographic Details of the Seekers of the Institution-A

Category		**Care seekers (Total 31)**	**Per cent**
Sex	Female	11	35.5
	Male	20	64.5
Religion	Christian	4	2.9
	Hindu	21	67.7
	Islam	6	19.4
Economic Status	APL	26	83.9
	BPL	5	16.1
Social Category	General	12	38.7
	OBC	18	58.1
	SC	1	3.2

Source: Data collected in fieldwork during 2018 June-Jan 19

Institution-B

In Institution-B, female respondents account for 53 per cent, which is higher than 47 per cent of males. The institution's social identity and location's demography have a significant role in attracting health seekers. It helps to attract people who belong to the same social identity

to the institution. It shows that 53 per cent of the respondents are Christians and every third person of the healthcare seekers (33%) belongs to the Hindu religion (Table-4.4).

The social identity and its charismatic routinisation and geographic distribution of people would possibly affect health seekers' behaviour. While considering economic status, 80 per cent of the respondents are from the APL category, and 70 per cent of the social category belongs to Other Backward Communities (OBC).

Table-4.4 Socio-Demographic Details of the seekers of the Institution-B

Category		**Care seekers (Total 30)**	**Per cent**
Sex	Female	16	53.3
	Male	14	46.7
Religion	Christian	16	53.3
	Hindu	10	33.3
	Islam	4	13.3
Economic Status	APL	24	80
	BPL	6	20
Social Category	General	20	23.3
	OBC	10	70
	SC	0	6.7

Source: Data collected in fieldwork during 2018 June-Jan 19

Institution-C

When analysing Institution-C, it is observed that male healthcare seekers comprise 63 per cent and female respondents comprise 37 per cent. In the case of religion, 60 per cent of the seekers belong to the Islam religion, and 33 per cent are Hindus. Christians constitute only 7 per cent of the respondents in the institution. The higher number of religious concentration is because of the geographical location of Institution-C, which is in Malappuram district, a Muslim populated place in Kerala (Table-4.5).

While considering the economic status based on the APL and BPL categories, a BPL family has less chance than an APL family to choose philanthropic initiatives. These categories constitute 33 and 67 per cent of the respondents, respectively.

Table-4.5 Socio-Demographic Details of the seekers from Institution-C

Category		Care seekers (Total 30)	Per cent
Sex	Female	11	37
	Male	19	63
Religion	Christian	2	7
	Hindu	10	33
	Islam	18	60
Economic Status	APL	20	67
	BPL	10	33
Social Category	General	7	23
	OBC	21	70
	SC	2	7

Source: Data collected in fieldwork during 2018 June-Jan 19

It can be understood in different ways, as well. In all the cases, the location of the institutes is one of the important aspects which influence seekers. The people with the same social identity are more attracted to the institution because of the power relationships. For instance, it is not by chance that a medical institution run by Christian management serves in a location where the middle-class Christian population is more concentrated. Similarly, Muslim identity in a Muslim-populated district would attract seekers while its parent organisation is located in Calicut, another Kerala district. The observation pertinent to this is that Malappuram is backward in healthcare infrastructure, and another is the demographic composition of the district. Both contribute to the growth of the institution.

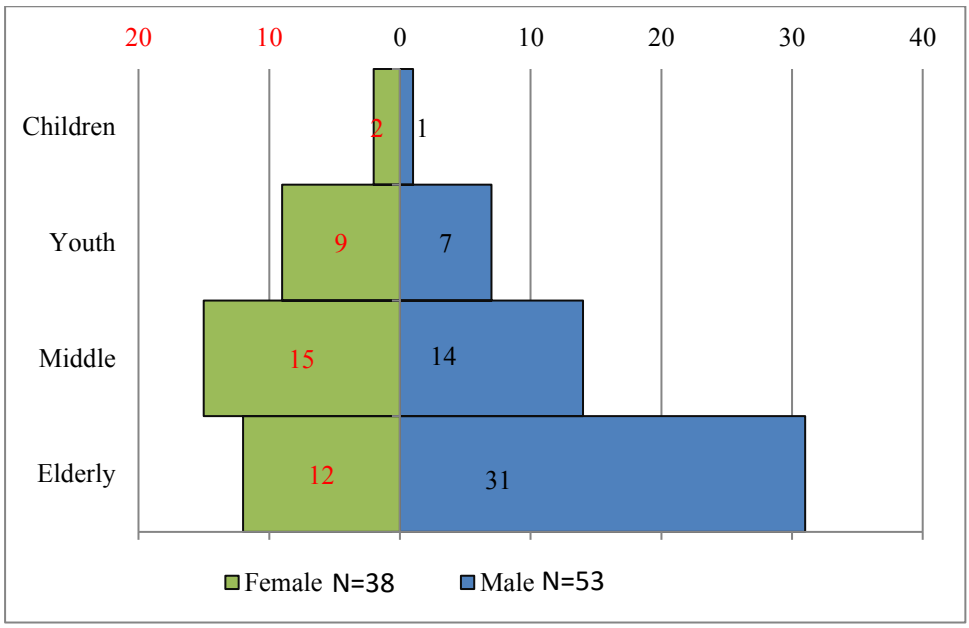
In a combination of tables (4.3, 4.4 and 4.5), the total male respondents are 58 per cent, and 42 per cent are females. APL category constitutes 77 per cent, indicating that a person with poor economic condition will have only limited access to services provided by philanthropic institutions. While analysing demographic constitution, 45 per cent are Hindus, 31 per cent are Muslims and 24 per cent Christians are there among those included in the respondents.

Age Distribution

The respondents falling under four age groups in two sex categories are shown in Figure-4.1. There are 53 males and 38 females that account for 58 and 42 per cent, respectively.

It includes Children (<16 years), Youth (17-35), Middle-aged (36-59) and Elderly (60<). Thirty-two per cent Middle-aged and 47 per cent Elderly constitute a significant portion of the respondents. There are 31 Males and 12 females in the Elderly age group. Within the elderly group, 72 per cent are male, which is three times higher than the female category. There is only a nominal difference between males and females in other age categories. Youths and Children constitute 18 and three per cent of the study population, respectively (Figure-4.1).

Figure-4. 1 Age Distribution in Sex Category (N=91)



Source: Data collected in fieldwork during 2018 June-Jan 19; Children=0-16, Youth=17-35, Middle=36-59, Elderly=60+

Geriatric care is one of the central departments in tertiary-care hospitals. As per the 2011 census, the elderly population in Kerala is 15 per cent and the projection is 30 per cent by 2023. Lifestyle (LSD), non-communicable diseases (NCD) between these two age groups are higher than the national average in Kerala. Economic Review-2018 reports that 52 per cent of the total deaths occurring in the age group of 30-59 are due to the NCD in Kerala.

These groups are vulnerable to diseases like cancer, cardiovascular diseases, obesity, hypertension and diabetes. Hence hospitals have a wide range of health check-up packages to accommodate them.

Forward and Backward Castes among the respondents

Observing caste in three religions is different in its practice. However, a general phenomenon can be seen that people from privileged castes groups have advantages or favourable social situations to access healthcare services when considering another caste group vulnerable to access resources due to their socio-economic hurdles. Hence, the categorisation has been considered on the ground of self-assertion.

In all the three institutions, socially and educationally, Forward Castes (FC) are more concentrated than Backward Castes (BC) among the seekers. FC includes Nayar, Pilla, Panikkar, Menon and Varma and BC includes Ezhava, Nadar and Pulaya in the Hindu community. In Christians, Syrian, Marthoma and Protestant falls under FC while Latin is in BC. Of the 91 respondents, Muslims constitute 29 and the remaining 62 are presented in Table-4.6.

Table-4.6 Caste Segregation of the users from each institute

Institution	**FC**	**BC**	Total-N
A	14	10	
	58%	42%	24
B	18	8	
	69%	31%	26
C	5	7	
	42%	58%	12
Total	**37**	**25**	**62**
	60%	**40%**	

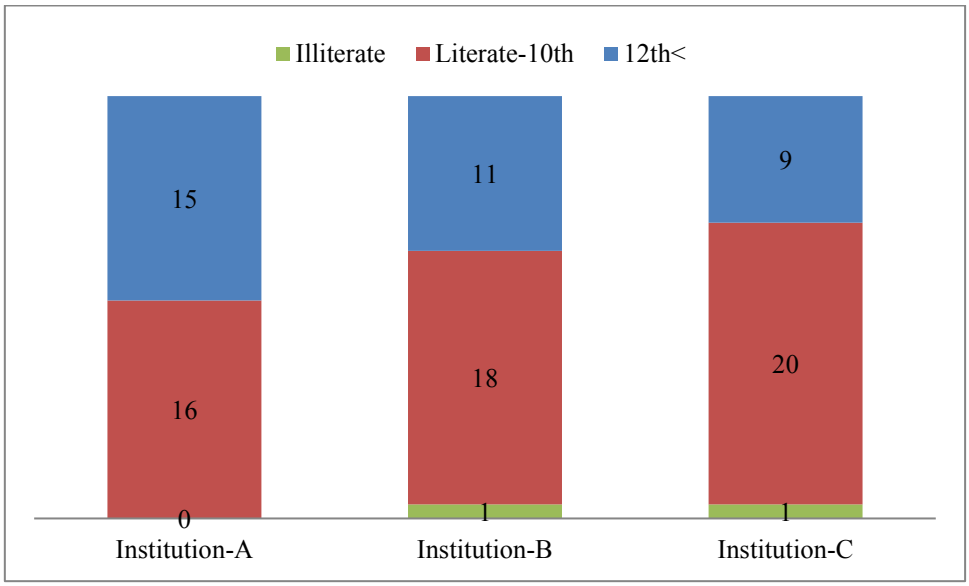
Source: Data collected in fieldwork during 2018 June-Jan 19
FC= Forward Caste, BC=Backward Caste

The FC in Institution-A is 58 per cent and 69 per cent in Institution-B. In the case of Institution-C, BC is 58 per cent, which is higher than 42 per cent of the FC share. Cumulatively, 60 per cent of seekers belong to the forward castes and 40 per cent are from backward castes. While in Kerala, 28 per cent of the total population represents the forward caste (Table-4.6). People from the forward-caste groups constitute a larger proportion in philanthropic institutions than backward castes. It is also important to note the absence of the Scheduled Tribe (ST) population in the tertiary care institutions. All these institutions are expensive and urban-centred; hence ST people cannot access them. However, they claim to have community outreach programmes to deliver care to such vulnerable groups.

Education Attainment Level

Education attainment has been categorised into three: illiterate people who did not have any formal education, Literate to 10th category, and 12th above education level. Figure-4.2 represents the education attainment of the people from the three institutions.

Figure-4.2 Education Attainment of the Respondents N=91



Source: Data collected in fieldwork during 2018 June-Jan 19

In the case of Institution-A, 15 people are in the 12th and above category and 16 are in the Literate-10th category. It amounts to 16 and 18 per cent of the total, respectively. Institution-B has a combination of 12 per cent (N=11) and 20 per cent (N=18) of the same categories in 12th< and Literate-10th, respectively. In Institution-C, 10 per cent (N=9) and 22 per cent (N=20) belong to 12th< and Literate-10th categories, respectively. Illiterate persons are negligibly low in all three hospitals.

While considering all the three hospitals, 38 per cent of the respondents attained a higher level of education and 59 per cent had middle-level education.

Geographical Characteristics

Residential Area of the Respondents

Residing area of the respondents shows another aspect of philanthropic hospitals. The residential area is classified into three; Municipality, Panchayat and Corporation. The classification is based on the administrative divisions in Kerala in which population and urbanisation are also considered.

Table-4.7 Residential Area of the Respondents N=91

Institution	Municipality	Panchayat	Corporation
A	16 (18%)	4 (4%)	11 (12%)
B	13 (14%)	17 (19%)	0
C	18 (20%)	12 (13%)	0
Total	**47 (52%)**	**33 (36%)**	**11 (12%)**

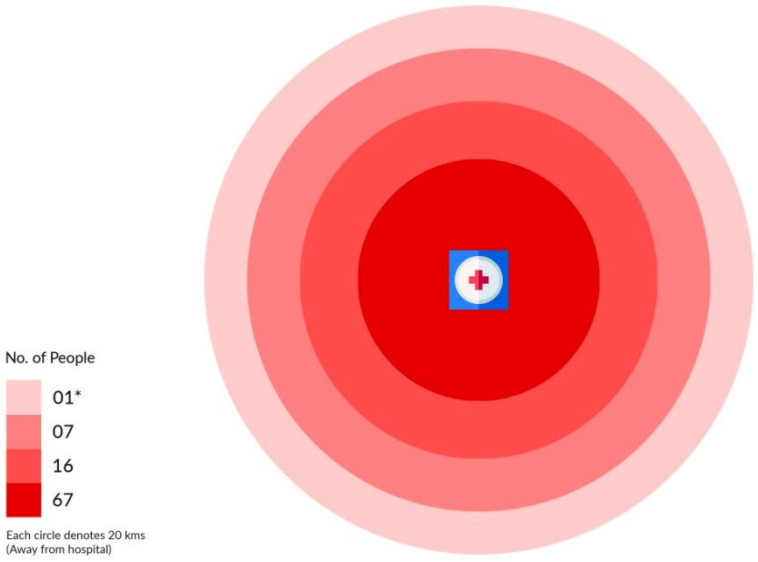
Source: Data collected in fieldwork during 2018 June-Jan 19

People who reside in Panchayat comprises 36 per cent of the total study population and 12 per cent are from the corporation. Fifty-two per cent of the sample reside in the municipality (Table-4.7). Cumulatively 64 per cent are from an urbanised location, that is, either municipality or corporation. It also indicates the urban-centric nature of philanthropic hospitals. Hence, people from villages or less urbanised locations have to cover more distance to access these services.

Distance Covered to Access the Service

Respondents travelled to access the hospital care, shown in Figure-4.3. It ranges from 160 kilometres (km) distance to five km. The nucleus of the circle is represented as a hospital, and each circle denotes 20 km. The outer circle represents the distance of 160 km from where one of the respondents accessed the care.

Figure-4.3 Distance Covered to Access the Hospital Care N=91



Source: Data collected in fieldwork during 2018 June-Jan Each circle denotes 20 kilometres from the hospital. *The outer circle denotes 160 Km

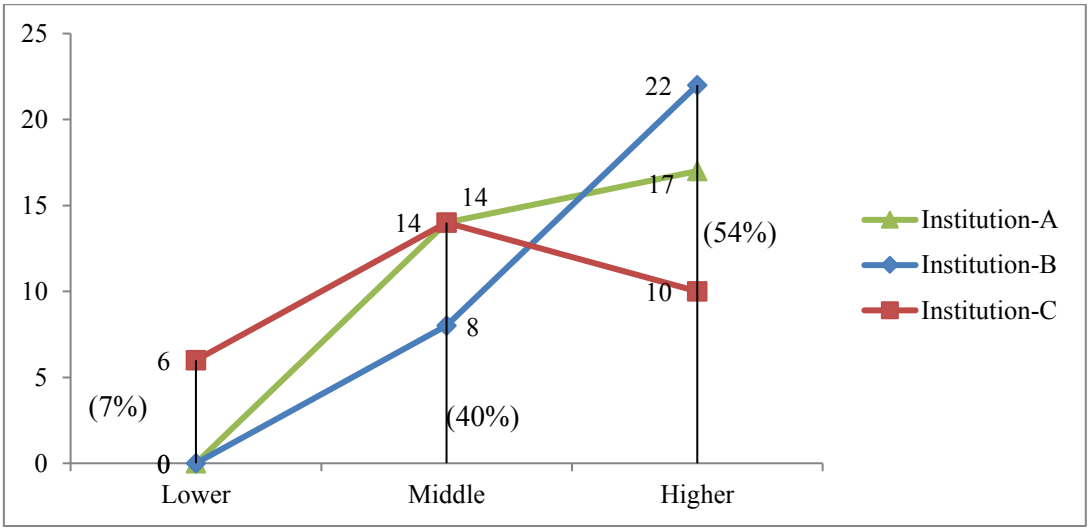
The majority of the users are close to the hospital. Seventy-four per cent of respondents access the care from a distance of 20 km. The second circle denotes 40 km and 18 per cent of the users access the hospital from there. It means that users from adjacent districts are also higher. That is, 90 per cent are either from neighbouring districts or from the same district where the hospital is located. It is observed that the location of the hospital is important in accessing care.

Economic Characteristics

Average Monthly Income of a Family

The respondents have been categorised into three groups based on the reported monthly income of the family. The categories are Lower, Middle and Higher-income groups. The classification has been carried out by taking the lowest and highest reported income and then dividing it into three groups. The exercise was done in SPSS itself. The lowest reported average income of a family is 12,000 per month. Hence, if a family's monthly income ranges between INR 12,000-25,000, they are considered the Lower-income category. Middle income ranges between INR 25,000-40,000. The higher-income group earns INR 40,000< per month (Figure-4.4).

Figure-4.4 Income Categories in the Study Population N=91



Source: Data collected in fieldwork during 2018 June-Jan 19 Lower= INR<25,000, Middle=25,000-40,000 and Higher=40,000<

In all the three institutions, the lower-income group is very few; that is, only six persons reported from a single institution, which constitute seven per cent of the total. Middle-income families comprise 14 each from Institution-A and C and eight from Institution-B. The total share of the second group is 40 per cent (N=36). Higher-income groups constitute 54 per cent

of the total population. They are the highest number; 49 persons are reported in the higher-income group (Figure-4.4).

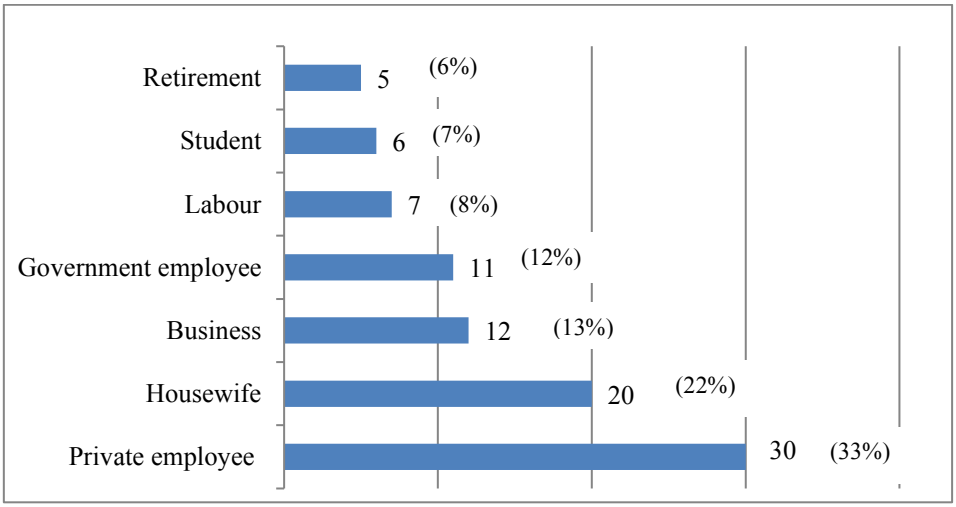
Only middle and higher-income groups can afford healthcare expenses in philanthropic institutions. Ninety-five per cent of the beneficiaries are either middle or higher-income groups in a philanthropic hospital. Lower-income categories are less attracted to these hospitals due to economic constraints. Tertiary care services for in-patients are costly, even in philanthropic hospitals (Figure-4.4).

Another aspect is also important in the case of religious or caste-based hospitals, which can be related here that people who belong to the higher wealth quintile are more attracted to the spiritual leaders in India. People from the higher wealth quintile seek physical and psychological well-being through these spiritual leaders. They believe that their economic prosperity is because of the blessings of particular *baba* or *amma*.

Occupation of Guardians

Figure-4.5 categorises the respondents based on their job. The reported occupations are government and private sector jobs, and people running shops or managing any initiative where other people work under a particular person are in the business category. Labour is working under an employer for daily wages who do not have any other means of income. The retirement category does not engage in an activity due to health constraints. Two more categories include students and housewives (Figure-4.5).

Figure-4.5 Occupation of the Respondents N=91



Source: Data collected in fieldwork during 2018 June-Jan 19

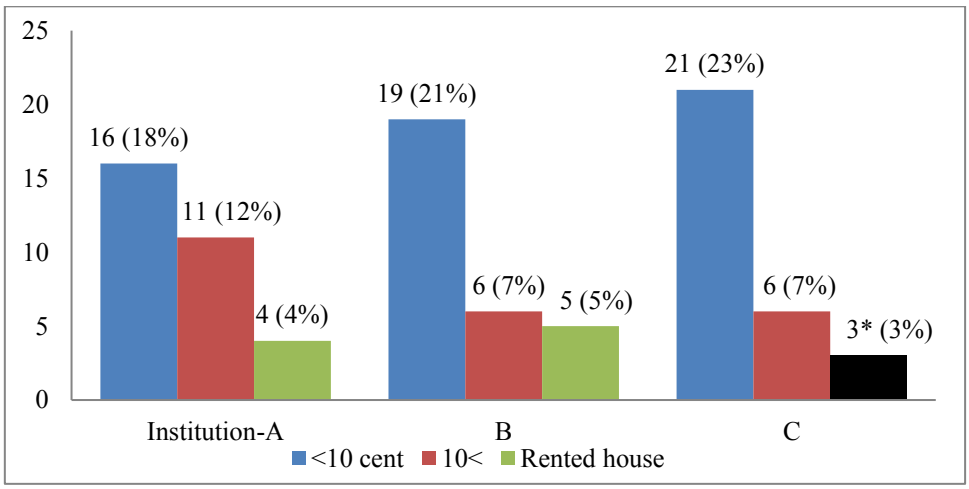
Among these, 33 per cent of the total (N=30) are private employees, which is the highest. Housewife constitutes 22 per cent (N=20) second-highest, among others. However, 47 per cent are working women within the female population of 38 persons. Government employees and persons engaged in business share are 12 and 13 per cent, respectively. Labours or daily wagers constitute eight per cent. Six per cent of the elderly who lead retirement life and seven per cent of students were also included in the total population (Figure-4.5).

While analysing the occupation, the striking fact is that 58 per cent of the total respondents have prosperous jobs. They are working in either public or private sectors. If we deduct those who are not doing any job like categories of 'housewife', 'student' and 'retiree', then the share is 91 per cent (N=53/58). Only eight per cent of the total population who access philanthropic hospitals for mild ailments are labourers or daily wagers due to economic and other specific reasons, which is discussed in the following sections.

Land Ownership

Land ownership is significant in the context of Kerala. The state's achievement in social development is attributed to many factors, including the Land Reform Act. The Act enforces a maximum limit on land ownership by a family, and the tenants got a claim over the excess land. However, the major criticism of the Act is that Dalits, tillers and tribals did not get the benefits even after fifty years of enactment. It is crucial to understand who an agriculture labourer without land is and a landlord. In this context, we analyse the land ownership of the study population (Figure-4.6).

Figure-4.6 Land Ownership in cents N=91



Source: Data collected in fieldwork during 2018 June-Jan 19 *Note= purely rental homes based on tenure agreement with zero land ownership to the residents, which is different from flat or villa

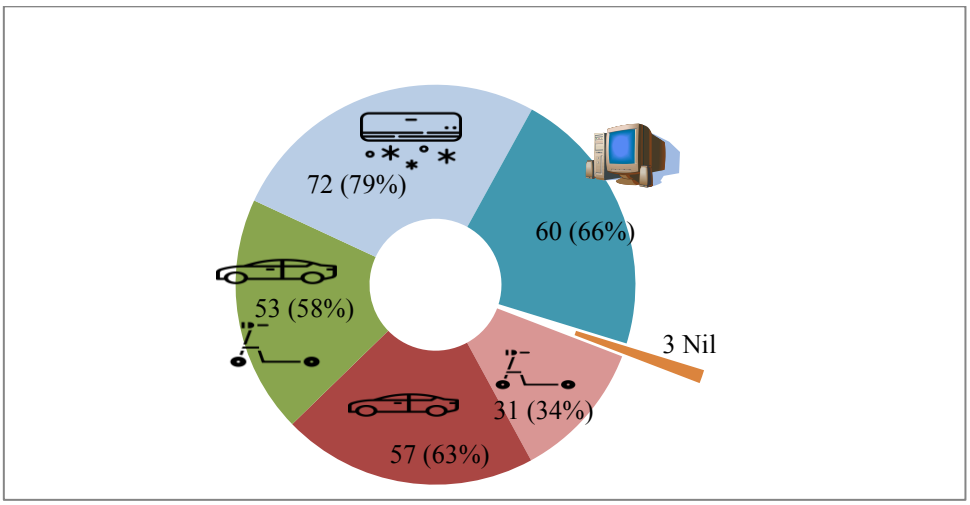
There are three categories: families with less than ten cents of land (100 cents is one acre), with more than 10 cents and families living in a rented house, either flat or villa. The leased category does not own land in legal terms and the unit of measurement is square feet for their home. Some respondents are different from the people living in a flat or villa in the rented category. The significant demarcation is that they are on a legal agreement for a term with comparatively lower monthly rent than a flat or villa setup. The living standard is completely different between these two categories, yet both are in the rented category.

There is 61 per cent (N=56) who fell in the category of up to ten cents ownership of land. While analysing the institutions separately, 51, 63 and 70 per cent of the beneficiaries from Institution-A, B and C belong to the up to ten per cent category, respectively. The remaining 20 per cent of the beneficiaries from Institution-B and C own more than ten cents of land. It is 35 per cent in Institution-A. It means that three persons out of four are wealthy in terms of land ownership and it does not mean that the remaining is poor. They are also rich and live in a villa or flat (Figure-4.6).

Household Assets

In this study, only a few assets are taken into account with consideration to the Kerala context; they are motorcycle, car, computer system and air-conditioner (AC). The number of vehicles per 1000 persons is 305 in Kerala, which is higher than in China and nearer to the United States and it is only 18 in India. Out of the total vehicles, 64 per cent are motorcycles and 20 per cent are cars.

Figure-4.7 Household Assets N=91



Source: Data collected in fieldwork during 2018 June-Jan 19

As per the latest report, one among every third Keralite has a motor vehicle. AC becomes an essential household asset in Kerala (Figure-4.7). Livestock has been omitted due to geographical differences in the study sites. Only a negligible section of the urban or town centred households were included in the study population, especially upper-class people who foster domestic animals.

Only three per cent of families reported that they do not own any of the listed assets. Households with AC is 79 per cent the highest constituent (N=72) among others. There is 66 per cent (60) households own a computer, 63 per cent own cars (57), 34 per cent own a motorcycle (31) and 58 per cent (53) own both car and motorcycle (Figure-4.7).

While these are assets converted into economic terms, the price of a single asset ranges from lower to high though it is treated as the same category. A luxurious and a low-end car would be in the same category, but the family's buying capacity is different. There is no upper and lower classification within the asset category.

Diseases and Cost of Care Reported by the Respondents

The reported illnesses are classified broadly as Chronic, Acute, Injury and Mild ailments. The classification was not based on technical definitions of these terms but operationally defined for the convenience of the study.

Table-4.8 Category of Diseases Reported N=91 (%)

Disease Type	Inst A	B	C
Acute	9 (10)	9 (10)	10 (11)
Chronic	12 (13)	8 (9)	11 (12)
Injury	8 (9)	7 (8)	5 (5)
Mild ailments	2 (2)	6 (7)	4 (4)

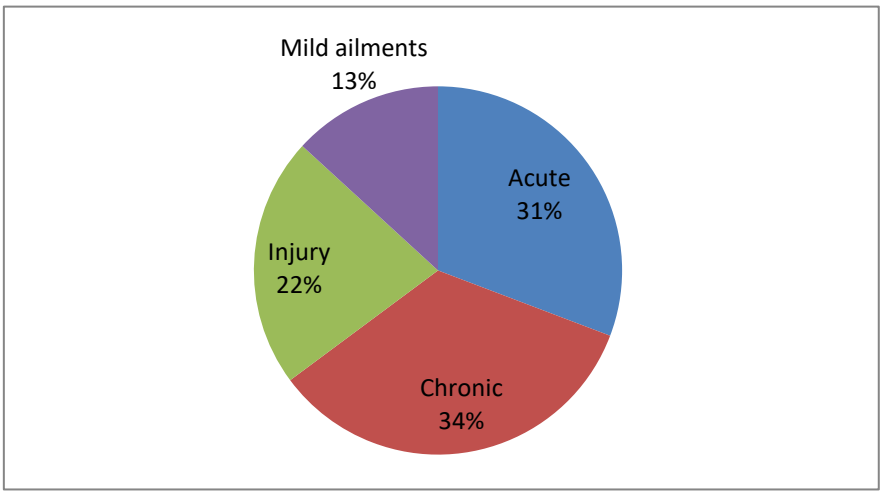
Source: Data collected in fieldwork during 2018 June-Jan 19. Acute= CVD surgery and organ transplantation Chronic= prolonged diseases like cancer, diabetes and hypertension Injury= due to fir-burn, fractures and other similar emergency care Mild ailments= OPD care like fever, cold, cough and skin diseases

Chronic diseases included cancer, diabetes, hypertension, and respiratory illness (Asthma), which needed frequent hospital visits along with hospitalisation. Diseases that required surgery and other similar one-time treatment were included in the acute category, like kidney transplantation, tumour removal, and cardiovascular surgery. In this case, hospitalisation and frequency of visits were comparatively less to the treatment for chronic diseases. Mild ailments

that include cold, cough, skin diseases, fever and different aches are largely dealt with in the outpatient department (OPD) care (Table-4.8).

Table-4.8 reveals that people who access care centres for mild ailments are remarkably low while comparing the care given for acute or chronic illnesses. It is two, six and four per cent of the total respondents in Institution-A, B and C, respectively. Altogether, care for mild ailments constitutes only 13 per cent of the total. All three institutions flagged their speciality as techno-centric tertiary-care services. Care receivers seek modern care facilities for non-communicable diseases (NCD). An almost equal number of users approaches the three institutions to care for acute and chronic diseases. Altogether, users who approach to care for acute illness are 31 per cent and for chronic illness is 34 per cent. The share of users who approach care for injury constitutes 22 per cent, which is also a significant portion of the total population (Table-4.8).

Figure-4.8 Disease Reported N=91



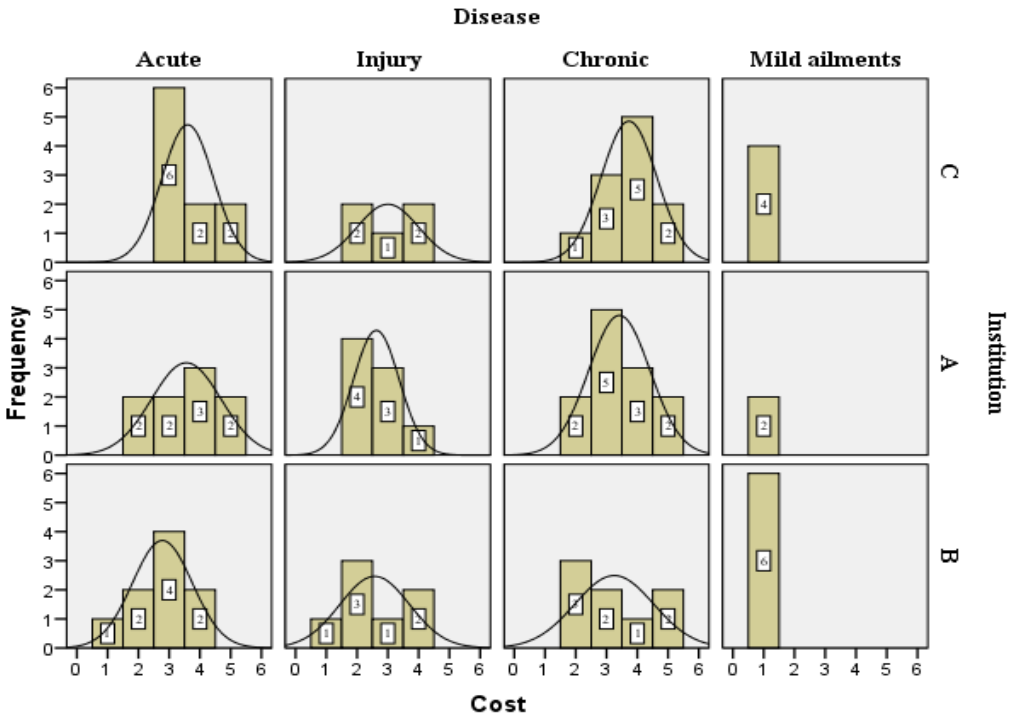
Source: Data collected in fieldwork during 2018 June-Jan 19

The observation can also be put in this way that every third person who approaches a tertiary care philanthropic hospital is either for acute or chronic disease care (Figure-4.8). If integrating these two diseases, 65 per cent of the users in these hospitals approach NCD care. It means that every second person would be in this category. Nearly one out of every fourth would be approaching them for injury care. The other part of this analysis is that cost of the treatment is unbearable to even rich people.

Cost of Diseases Treated in the Institutions

An analysis of treatment costs in the three institutions reveals another aspect of the phenomenon. Figure-4.9 represents the cost at the bottom of the X-axis and disease at the top. Institution-A, B and C are represented separately and the number of users treated can be viewed in the Frequency axis vertically. Here, the cost is denoted by numerals from one to five, in which one represents expenses up to INR 5,000 and two stands for 5,000 to 10,000. Treatment cost which exceeds 10,000 but not more than 25,000 is under number three. If it is between 25,000 and 75,000, it is denoted by four. The number five represents the treatment cost beyond 75,000 (Figure-4.9). The disease category was explained in the previous section.

Figure-4.9 Cost of Treatment for the Diseases in Institutions



Source: Data collected in fieldwork during 2018 June-Jan 19

All three institutions concentrate on techno-centric care for non-communicable diseases and emergency care rather than primary care. While observing Figure-4.9, the cost is curved in acute, chronic diseases and injury care. The number of users in every institution is from three to six in these disease categories. The peak of the curve lies between three and four, which denotes the expense of INR 10,000 to 75,000. Forty-eight persons are in the third and fourth cost category, starting from 10,000 to 25,000 and 25,000 to 75,000, respectively (Table-4.9).

Table-4.9 Category of Cost and Diseases Treated (N=91)

Disease/Cost in 000	<5	5-10	10-25	25-75	75<	Total
Acute	1	4	12	7	4	**28**
Injury	1	9	5	5	0	**20**
Chronic	0	6	10	9	6	**31**
Mild ailments	12	0	0	0	0	**12**
Total N	**14**	**19**	**27**	**21**	**10**	**91**

Source: Data collected in fieldwork during 2018 June-Jan 19

In a philanthropic hospital, 43 per cent of people with acute illnesses, that is, half of the total care receivers, spend an average of INR 17,500 on treating the disease. Similarly, one in every three persons with chronic disease spends the same for the treatment. There are 25 and 29 per cent of the persons with the same disease categories who pay nearly INR 50,000 for the treatment. It is in the case of disease category. If it is applied to the total users, every third user spends an average of INR 17,500 and every fourth user spends an average of INR 50,000 for the care (Table-4.9).

Mode of Payment

The users pay hospital bills in four ways that are given in Table-4.10. These are government insurance for healthcare, insurance provided by private companies or employers, payment through own means and money rolling from other sources temporarily as they are indebted.

Rolling and spending from own income source are the highest among others which constitute 37 per cent each. Every third person is indebted due to their healthcare expenditure in philanthropic hospitals. One out of four users (21%) utilises government health insurance in these hospitals. Private insurance is the lowest with a four per cent share. The utilisation of government insurance and money rolling is highest in Institution-A with nine and 15 per cent share among others (Table-4.10).

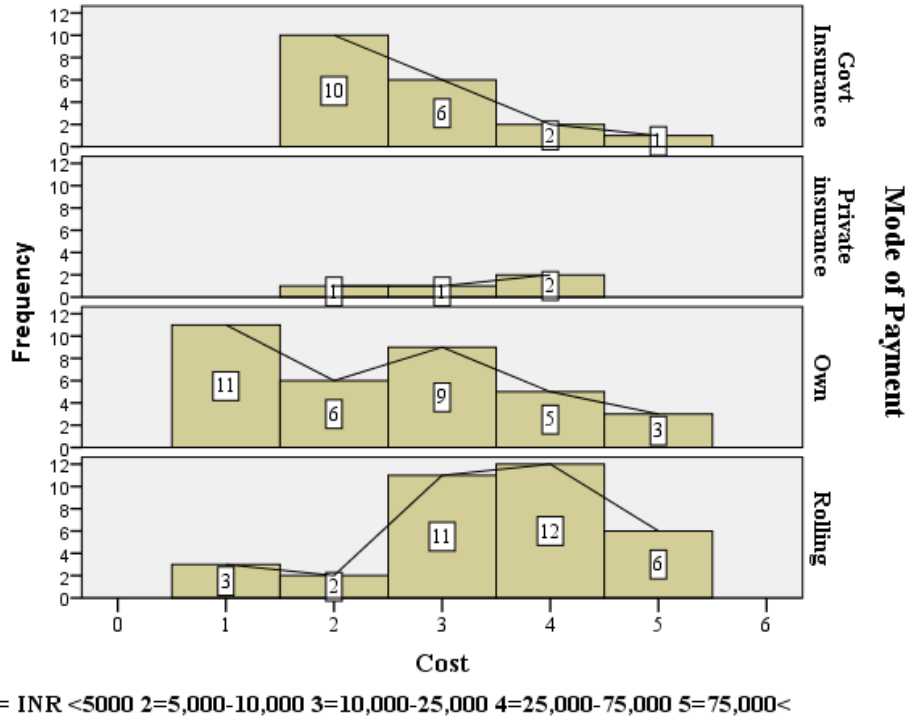
Table-4.10 Mode of Payment in Different Institutions N=91

Institution	Govt insurance	Private insurance	Own	Rolling
A	9	1	6	15
B	7	1	14	8
C	3	2	14	11
Total	**19 (21%)**	**4 (4)**	**34 (37)**	**34 (37)**

Source: Data collected in fieldwork during 2018 June-Jan 19

The cost division of the payment mode is given in Figure-4.10. The Y-axis illustrates the payment mode and number of users who used different modes, while the X-axis represents cost divisions ranging from one to five. There are four payment modes and five cost divisions.

Figure-4.10 Cost Incurred and Mode of Payment



Source: Data collected in fieldwork during 2018 June-Jan 19

It is observed from the figure that in government insurance, the highest number of users in the second cost category is ten and six persons is in the third cost category. It constitutes 33 and 20 per cent within the mode of payment, respectively (Figure-4.10).

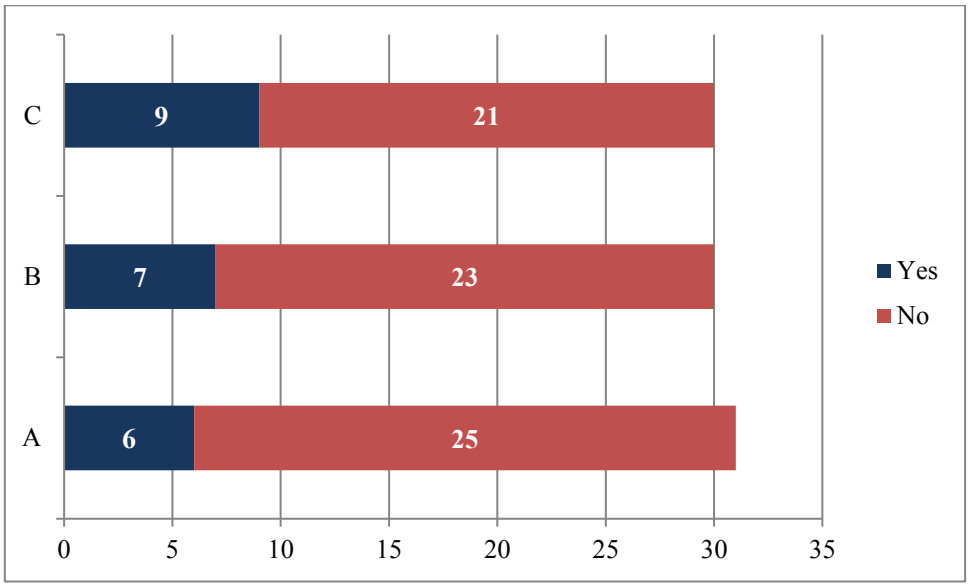
The inference is that the 'Own' and 'Rolling' payment mode shows that the number of users concentrated in opposite divisions in these two categories. When the cost of care is lower,

the mode of payment is 'Own' and when the cost is higher, the payment mode is 'Rolling'. The interpolation line shows an upward trend when moving towards the right side of the X-axis in 'Rolling' mode and the line shows a downward trend in 'Own' payment mode (Figure-4.10).

Reduction in the Hospital Fee

The charity hospitals provide a reduction in the overall amount incurred for the care. Twenty-two users benefitted out of 91 in all three hospitals, which constitute 24 per cent of the total. Institution-C has the highest number of people getting benefited from the reduction. Only one out of four users benefited from the reduction in these hospitals (Figure-4.11). The remaining 76 per cent did not get any reduction in the bill.

Figure-4.11 Reduction in the Hospital Fee N=91



Source: Data collected in fieldwork during 2018 June-Jan 19

Factors Which Contribute to Leaving and Selecting a Healthcare Facility

The care users' choice between the private and public hospitals before they approach a particular philanthropic facility for treatment is also surveyed in the study. People who accessed philanthropic hospitals reported on their selection of a healthcare facility at the outset of disease, as shown in Table-4.10. The question was whether they accessed any other healthcare facility before the philanthropic facility.

Table-4.11 Selecting a Healthcare Facility at the outset of Disease N=91

Institution	Public	Private	Philanthropy
A	13	4	14
B	10	1	19
C	7	0	23
Total (%)	**30 (33)**	**5 (5)**	**56 (62)**

Source: Data collected in fieldwork during 2018 June-Jan 19

Thirty-eight per cent of users accessed either public (N=30) or private centres (N=5) before they came to philanthropic hospitals. Three different responses are shown in Table-4.10, where 33 per cent of the respondents accessed public hospitals at the onset of a disease. They leave those hospitals on specific grounds and access philanthropic facilities. A more significant section of the respondents from a philanthropic institution directly accesses the hospital without going to any other facility on specific grounds. It comprises 62 per cent of the total.

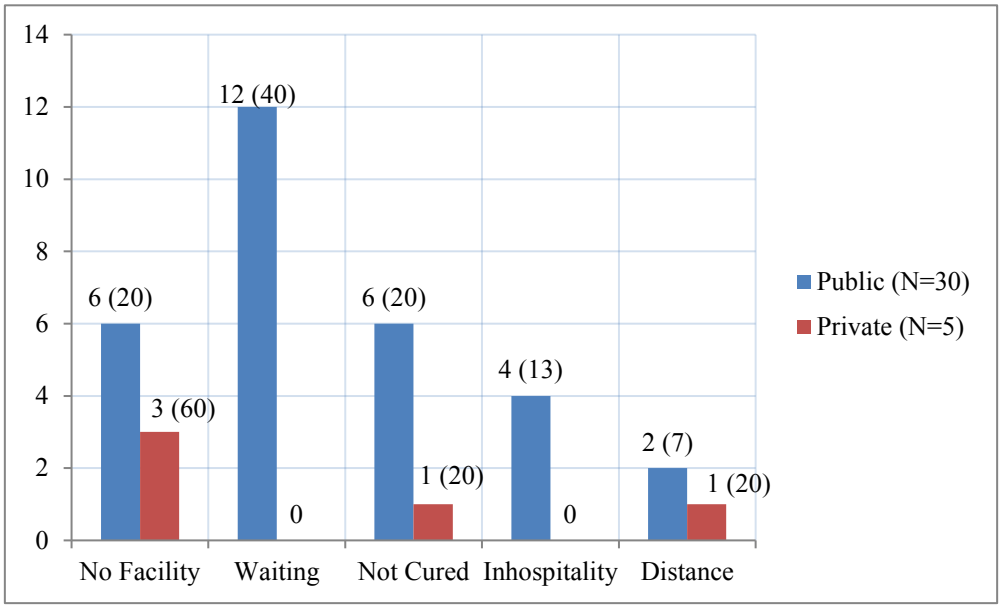
Forty-one per cent of users (N=13) from Institution-A accessed and left public hospitals before this facility. Similarly, one in every third person from Institution-B accessed public hospital before coming to this facility and 23 per cent from Institution-C did the same. In the case of private care, only five per cent accessed it directly without approaching a public hospital first. It is observed from the table that every third user of the total respondents (N=33/91) prefers public hospitals and access them. However, they left it and selected philanthropic hospitals on specific grounds.

Factors for Leaving a Hospital

Every third user prefers public hospitals and five per cent prefer private of the total, yet they leave it due to different factors. Figure-4.12 indicates five factors for leaving either a public or a private hospital. Out of the 91 users, 35 accessed another facility before coming to philanthropic care. In which 30 for public and five for private. It is a response to an open-ended question and the answers were later classified into five categories.

One of the options, “No Facility”, contains a range of replies, including doctors’ unavailability, time barrier and technical failure. Another response is ‘Waiting’ in public hospitals that restrict them to get essential services. The waiting sometimes takes six months or one year before reaching their turn after the first contact with the doctor. It is difficult to wait for many users who expect speedy recovery and relief. The third reason for leaving a public hospital is ‘Not cured’ in which users find fault with service providers.

Figure-4.12 Factors for Leaving a Hospital N=35



Source: Data collected in fieldwork during 2018 June-Jan 19

The inhospitality of the service providers in the former healthcare facility is also a factor for leaving. One more reply was 'Distance' to the public or private hospitals, which caused difficulty in making multiple visits as required in some cases (Figure-4.12).

It is observed from Figure-4.12 that the largest share of care receivers who leaves public hospitals due to the long waiting period comprises 40 per cent of the total. Twenty per cent of users left a public hospital due to the lack of facility. While another 20 per cent left it due to the disease being 'not cured'. Care receivers faced discomfort due to the inhospitality of service providers in the public hospitals, comprising 13 per cent left on this ground. Seven per cent stated the distance to the nearest public hospital as a reason to leave.

Factors for Choosing a Philanthropic Hospital

It is also analysed the factors of selecting a philanthropic hospital over public or private care facilities. The reported reasons are listed in Table-4.12 along with Institution-A, B and C. In these hospitals, 25 per cent of the users accessed care because of well-known doctors' availability. Another 24 per cent accessed it because it is 'Near' and 'Referred', which constitutes the same. Modern facility and speciality to identifying and treating diseases are among the pulling factors of selection to 19 per cent people (Table-4.12).

Table-4.12 Factors for Choosing a Philanthropic Hospital N=91

Factors/Institution	A	B	C	Total N=91
Speciality	5	11	1	17(19)
Near	7	6	9	22(24)
Quality	2	3	2	7
Referred	8	5	9	22(24)
Well Known Doctor	9	5	9	23(25)
Total	**31**	**30**	**30**	**91**

Source: Data collected in fieldwork during 2018 June-Jan 19

The observation from the table is that individual and institutional charisma is a significant factor in selecting a philanthropic hospital. Unique tags of a doctor and modern technology attract 44 per cent of the users, which is well utilised by a philanthropic hospital (Table-4.12).

Factors of Selecting a Hospital and Reported Diseases

Among the 23 users who selected philanthropic hospitals on the ground of well-known doctors' availability, 56 per cent reported acute diseases and 26 per cent said chronic disease conditions (Table-4.13). In the 'Referred' factor, 45 per cent reported chronic illness. Similarly, 41 per cent of the users in the 'Speciality' said acute diseases. The observation based on Table-4.13 is that users selected these hospitals on major disease conditions that need the best critical care facility.

Table-4.13 Factors for Selecting Philanthropic Hospitals and Disease Reported N=91

Factor & Disease	Acute N=28	Injury N=20	Chronic N=31	Mild N=12	Total N=91
Speciality	7(41)	4	5	1	**17**
Near	3	7(32)	8(36)	4	**22**
Quality	0	3	2	2	**7**
Referred	5	5	10(45)	2	**22**
Well Known Doctor	13(56)	1	6(26)	3	**23**

Source: Data collected in fieldwork during 2018 June-Jan 19

The Practice of a Religion and Self-reported Religiosity of the Respondents

There are questions to understand the degree of religiosity and practice of religion among care receivers. The respondents were categorised into four based on the responses given

to the questions (Table-4.14). The categorisation was based on religious identification, religious attachment and religious behaviour (Solt et al., 2011). Apart from this, the religious activity is analysed in terms of attending religious functions, participation in prayers and association with religious centres (Nanda, 2009). Moreover, the self-identification of a respondent towards their religious attitude was given more weight.

Table-4.14 Practice of Religion and Self-reported Religiosity of the Respondents N=91

Religion (N)	Religiose	Moderately	Selectively	No
Christian (22)	9	4	6	3
Hindu (41)	13	12	8	8
Islam (28)	10	3	11	4
Total	**32 (35)**	**19 (21)**	**25 (27)**	**15 (17)**

Source: Data collected in fieldwork during 2018 June-Jan 19

The respondents with no religious practices are under 'No', yet they have not denied religious identity. Hence, their religion is marked in the table. One of the categories is 'Religiose', who have strong ties with religious centres and other customs. They are regular practitioners and attend other religious activities in the centres. Moderately religious people believe in a particular religion but do not participate in regular prayers but associate with temporal functions and rituals. 'Selectively' religious are neither Religiose nor Moderately believers but perform only some rituals related to family or religious centres without leading a practising life (Table-4.14).

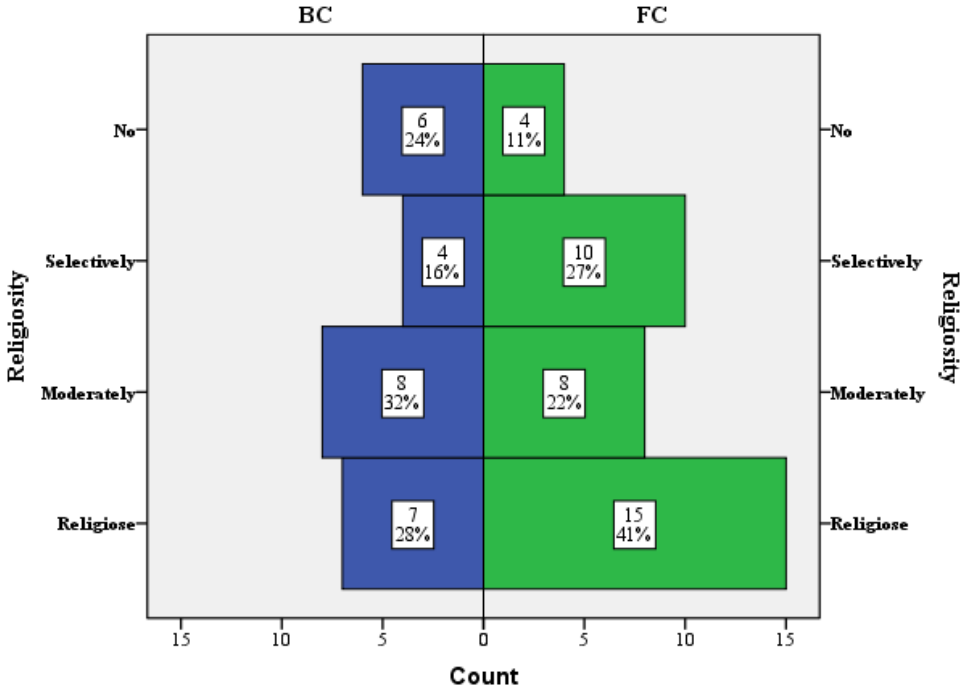
Altogether 35 per cent of the total respondents are Religiose and 21 per cent are 'Moderately' religious. A considerable share of people are 'No religiosity' (17%) and 27 per cent are 'Selectively' religious. Religiose are highest among Christians (41%) within the religious groups than the other two groups. They are 35 per cent among Muslims and 31 per cent among Hindus. There are 19.5 per cent who did not express religiosity in Hindus and 14 per cent each from Christians and Muslims are not religious. Cumulatively, 83 per cent of the respondents have religious beliefs with different degrees of religiosity (Table-4.14).

Religiosity among Forward and Backward Castes

Sixty-two respondents reported that they have caste, within that 37 are considered socially and educationally Forward Caste (FC) and 25 are Backward (BC) in Kerala. FC comprises 60 per cent and 40 per cent in BC (Figure-4.13).

Figure-4.13 shows that 41 per cent of the users from FC are Religiose and in BC, it is 28 per cent. The highest among BC is in the 'Moderately' religious group that constitutes 32 per cent of the BC. Users who replied 'No' religious practices comprise 24 per cent in BC and 11 per cent in FC. The observation drawn from the figure is; socially and educationally developed people are comparatively more religious than less developed sections. It also proves that Kerala is a caste and religious-based state where these identities are as influential as money.

Figure-4.13 Religiosity among Forward and Backward Castes N=62



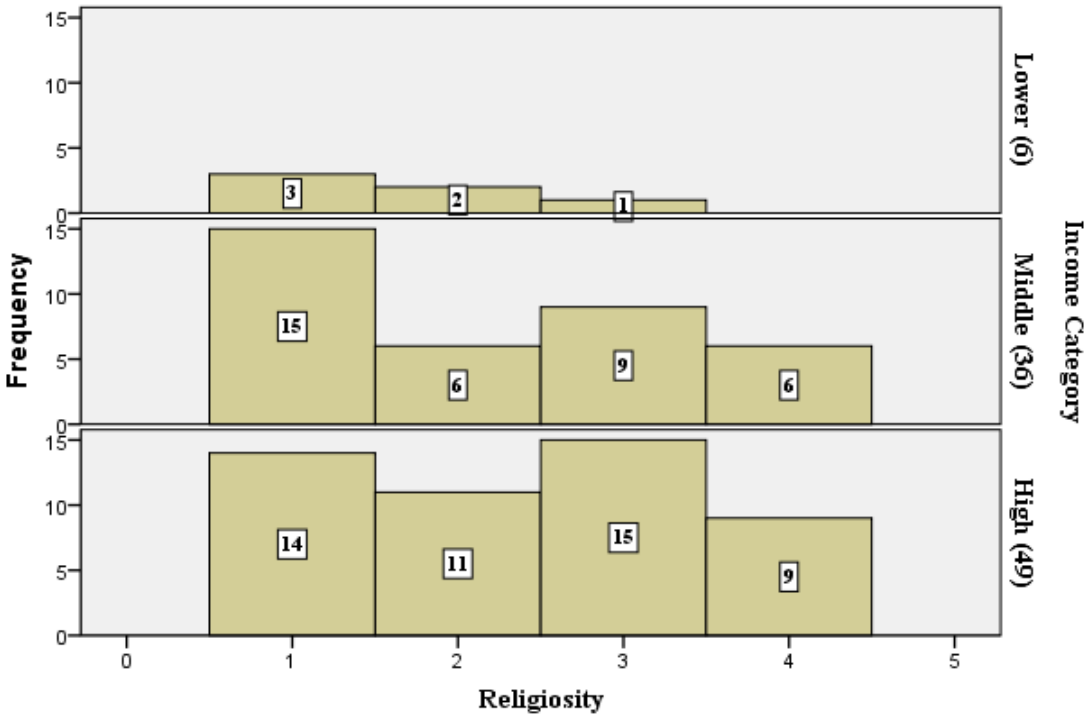
Source: Data collected in fieldwork during 2018 June-Jan 19 *BC=25 FC=37

Income and Religiosity

Among overall respondents, three income categories are reported: lower, middle, and high-income groups. Each of the categories has six, 36 and 49 users, respectively. Figure-4.14 indicates that 50 per cent of the lower-income respondents (that is three out of six), 42 and 28 per cent of the middle and high-income respondents are 'Religiose' in each category, respectively. However, persons who responded 'No' religiosity in middle income is 16 per cent and 18 per cent in higher-income groups. In the lower-income group, everybody is religious to different degrees.

Religiosity is higher among lower-income families, yet the proportionate share is considerably high in other income groups. Economic vulnerability makes individuals more religious as prosperity does (Figure-4.14).

Figure-4.14 Income Categories and Religiosity N=91



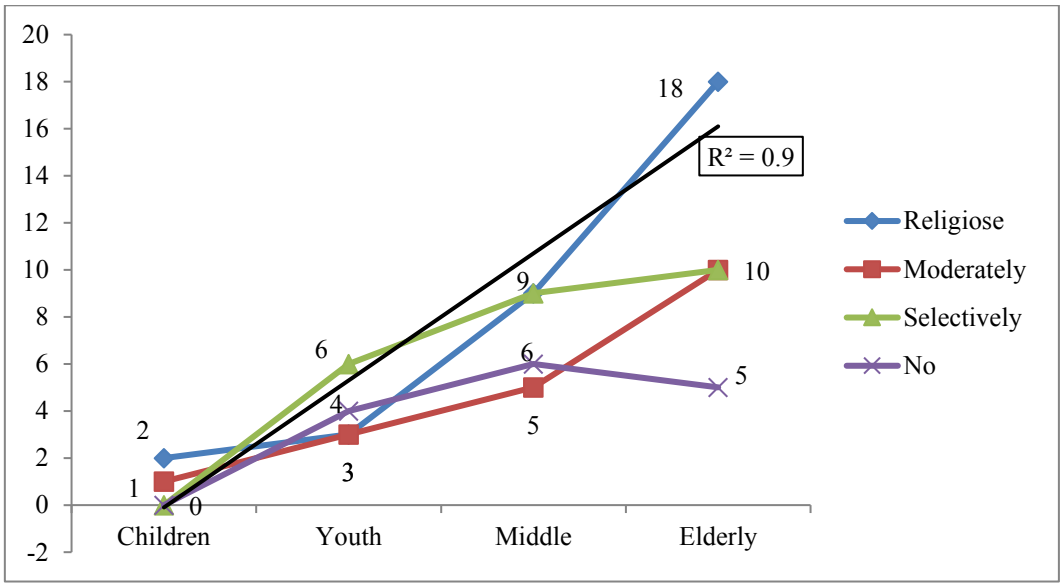
Source: Data collected in fieldwork during 2018 June-Jan 19 *(Income in 000) Lower= INR<25, Middle=25-40 and Higher=40< *1=Religiose 2=Moderately 3=Selectively 4=No

Religiosity in Different Age Groups

Figure-4.15 represents religiosity among Children, Youth, Middle and Elderly. Respondents from 0-16 ages are treated as Children and 17-35 ages belong to Youth. Middle age is 36-59 years and the Elderly is 60 years above (Figure-4.15).

It can be observed from the figure that religiosity is directly proportional to age. The elderly who are 'Religiose' constitutes 20 per cent of the total, which is the highest among other groups. Within the 32 'Religiose', 18 persons belong to the elderly, which comprises 56 per cent of the group and 28 per cent of the 'Religiose' are middle-aged persons. Similarly, 52 per cent of the 'Moderately' believers are elderly people. In the 'No' religiosity group, 27 per cent are Youth and 40 per cent are middle-aged people (Figure-4.15).

Figure-4.15 Religiosity in Different Age Groups N=91



Source: Data collected in fieldwork during 2018 June-2019, Jan Children=0-16, Youth=17-35, Middle=36-59, Elderly=60<

Elderly are comparatively higher in all groups and the highest share of the total are religiose elderly. The linear trend-line of the elderly is given in the figure and the R-square value is 0.9, which shows that religiosity increases as age increases (Figure-4.15).

Education Attainment and Religiosity

Table-4.15 indicates the educational attainment and religiosity of the respondents. Religiosity is proportionately higher among educated respondents. There are two illiterate respondents, 54 persons in 1st to matriculation and 35 in the higher-secondary and above category. In the '1st to matriculation' category, 35 per cent (N-19) and in the higher-secondary<, 34 per cent (N-12) are Religiose. One in every third of both categories is a religiose person.

Table-4.15 Education Attainment and Religiosity

Education Attainment	Religiose	Moderately	Selectively	No	Total
Illiterate	1	1	-	-	**2**
1>Matriculation	19 (35)	15 (28)	13 (24)	7 (13)	**54**
Higher Sec<	12 (34)	3 (9)	12 (34)	8 (23)	**35**

Source: Data collected in fieldwork during 2018 June-Jan 19

In these categories, persons with 'No' religiosity constitute 13 and 23 per cent, respectively. It is evident from the table that the degree of religiosity is higher among people with middle-level education attainment (Table-4.15).

Religiosity and Disease Reported

It can be observed from the table that persons with 'Chronic' diseases expressed the highest religiosity within the disease category (42%) and to the total (14%) as well (Table-4.16). Their share is lowest in 'No' religiosity, constituting only 13 per cent within the category.

Table-4.16 Religiosity of Persons with Reported Diseases

Diseases	Religiose	Moderately	Selectively	No	**Total**
Acute	9 (31)	4 (14)	8 (28)	7 (25)	**28**
Chronic	13 (42)	6 (19)	8 (26)	4 (13)	**31**
Injury	8 (40)	5 (25)	5 (25)	2 (10)	**20**
Mild	2 (17)	4 (33)	4 (33)	2 (17)	**12**

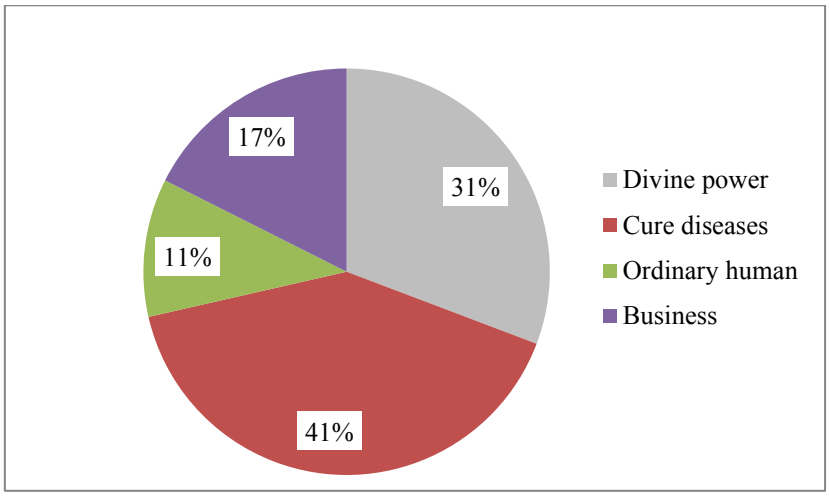
Source: Data collected in fieldwork during 2018 June-Jan 19

Users with 'Acute' diseases show the highest religious (31%) within the disease category and 10 per cent of the total respondents, which is the second-highest. At the same time, the highest share of persons who responded to 'No' religiosity is in the 'Acute' category, which comprises 25 per cent only. Religiose constitutes 40 per cent within the 'Injury' category and persons seeking care for mild ailments are comparatively not religious (Table-4.16)

Belief in Charismatic Power of Spiritual Leaders

By charismatic power, here we mean that it is associated with a caste or religious leader in the context of Kerala. Questions about respondents' belief in the charisma of a god-man (god-woman also) were included in the questionnaire. They associate with philanthropic foundations. In charisma, here we included specific characteristics of god-men. 'Divine power' entertains the followers by showing miracles and people believe that they 'cure diseases' through sanctity. At the same time, people believe that they are 'ordinary human beings' and others say it is a 'business' of selling spirituality (Figure-4.16). Based on it, 31 per cent of the population believe that spiritual gurus have divine powers but do not cure diseases, but 41 per cent of the total believes that they cure diseases with the help of miracles and sanctity.

Figure-4.16 Respondents Believing in Charisma N=91



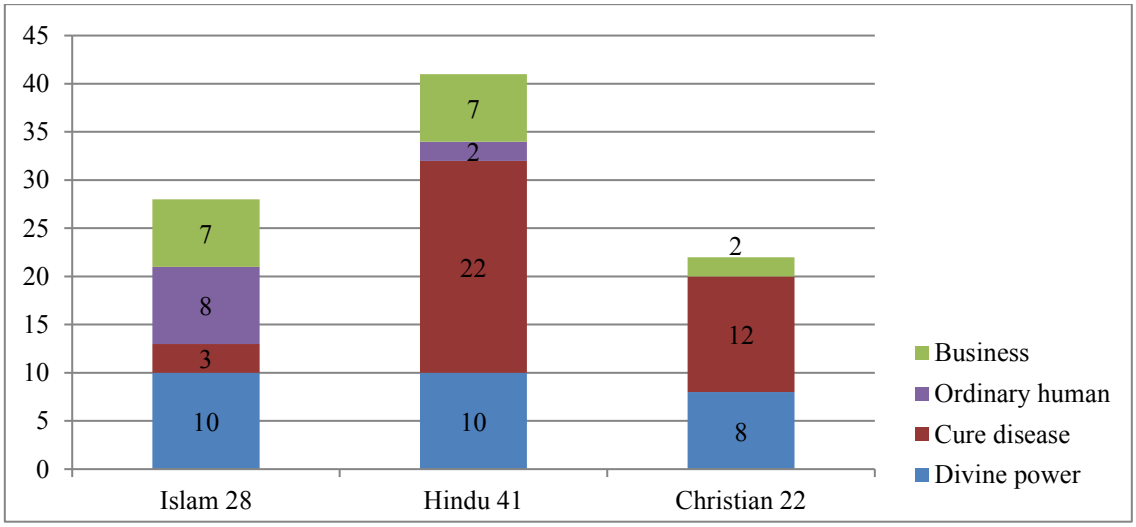
Source: Data collected in fieldwork during 2018 June-Jan 19

However, 17 per cent of the total says that gurus do business for money and 11 per cent believe that they are ordinary people with no sanctity. The observation from the figure is that 72 per cent of the people consider gurus are supposed to have sanctity and only 28 per cent denied it.

The Religion of Respondents and Belief in Charisma

People who believe in charisma based on their religion are shown in Figure-4.17. Christians and Muslims who believe that god-men have divine power constitute 36 per cent each. However, 54 per cent of Hindus and 50 per cent of Christians believe that god-men have divine power and cure diseases with their miracles.

Figure-4.17 Belief in Charisma and Respondents' Religion N=91



Source: Data collected in fieldwork during 2018 June-Jan 19

At the same time, 29 per cent of Muslims believe that they are ordinary people and another 25 per cent of Muslims firmly believe that they exercise it as a business for money. The belief among Hindus is five and 17 per cent, respectively (Figure-4.17).

The significant observation from Figure-4.17 is that there is a scope for legitimising god-men in every religion. Among Christians, 91 per cent of respondents legitimise the sanctity of god-men, while it is 54 per cent among Hindus and 46 per cent among Muslims. The remaining share of respondents from each religion rejects the sanctity of any individual.

Belief in Charisma and Self-reported Religiosity

Among the respondents who practice religion, the degree of religiosity varied; this is categorised into three. Table-4.17 shows that 50 per cent of religiose says that god-men can cure diseases. Among moderately and selectively religious, 42 and 40 per cent believe in the curing power of the god-men, respectively.

At the same time, 22 per cent of the religiose denies any sanctity to the god-men and nine per cent believe that they do business for money. While among selectively religious, 24 per cent think that the spiritual leaders do business for money. Interestingly, 40 per cent of users who say that they are not religious believe in the divine power of god-men. Another 20 per cent of them believe that god-men can cure diseases. At the same time, one out of every third person from them denies this sanctity (Table-4.17).

Table-4.17 Belief in Charisma and Religiosity of Respondents N=91

Charisma	Religiose	Moderately	Selectively	No
Divine power	6	8	8	6
Cure diseases	16(50%)	8(42)	10(40)	3
Ordinary human	7	1	1	1
Business	3	2	6	5
Total	**32**	**19**	**25**	**15**

Source: Data collected in fieldwork during 2018 June-Jan 19

In short, half of the users believe in the curing power of god-men irrespective of the degree of religiosity. People who express ‘no religiosity’ in life share similar beliefs about the god-men. It proves the disseminated charismatic power of these ‘men’.

Belief in Charisma among Educated

The belief in the charismatic power of the god-men among people with different education levels has been analysed in Table-4.18. Out of six lower-level educated people, 30 per cent believe in divine power and another 30 believe in curing the power of god-men. In middle-level educated respondents, 30 per cent believe in these two powers. Considerable shares of higher-educated people, which constitute 46 per cent, also believe that god-men cure disease using their sanctity (Table-4.18).

Table-4.18 Education Attainment and Belief in Charisma N=91

Education	Lower	Middle	High
Divine power	2	11(30%)	15(31)
Cure diseases	2	11	23(46)
Ordinary human	1	5	4
Business	1	9	6
Total	6	36	49

Source: Data collected in fieldwork during 2018 June-Jan 19

However, 14 per cent among the middle educated denies their sanctity and 25 per cent strongly believe that it is a moneymaking business. The education attainment of respondents does not influence their belief in the supernatural power of spiritual leaders. Highly educated people are comparatively more attracted to these men's divine power and sanctity than the less educated (Table-4.18).

Caste and Belief in Charisma

Sixty-two people claim the caste identity, of which 37 belong to Forward Caste (FC) and 25 belong to Backward Caste (BC). In the FC group, 65 per cent believe that god-men cures diseases and 40 per cent in BC do the same. Only 24 per cent from BC and 5 per cent from FC consider it as a moneymaking business. Simultaneously, 30 per cent from FC and 28 per cent from BC believe only in divine power and not in curing diseases. Socially and economically forward, caste groups have a higher inclination towards the divine power of spiritual gurus.

Table-4.19 Forward and Backward Caste Groups' Belief in Charisma N=91

Caste	FC	BC
Divine power	11(30)	7(28)
Cure diseases	24(65)	10(40)
Ordinary human	0	2
Business	2	6
Total	**37**	**25**

Source: Data collected in fieldwork during 2018 June-Jan 19

However, people from both caste groups are mesmerised by the aura of 'sacred' gurus despite the disparity in social development. It is less likely that people who claimed caste as a social identity and privilege reject the sanctity of god-men (Table-4.19).

Age and Belief in Charisma

Irrespective of the age differences, all the respondents believe in god-men's divine power and their power to cure diseases. The highest share of respondents is from the 'Middle-aged' group, which comprises 52 per cent within the group and they believe in the healing power of god-men. The Elderly is at second position in the same belief with a share of 42 per cent within the group. A growing generation of Youth who constitutes 44 per cent identifies the 'spiritual gurus' as a part of money-business. However, we can observe from Table-4.20 that, in the latter part of life, they are inclined to the sanctity of gurus to get relief from distressing life situations.

Table-4.20 Belief in Charisma in Different Age Categories N=91

Age	Children	Youth	Middle	Elderly
Divine power	1	6	6	15
Cure diseases	1	2	16	18
Ordinary human	0	1	2	7
Business	1	7	5	3
Total	**3**	**16**	**29**	**43**

Source: Data collected in fieldwork during 2018 June-Jan 19

Disease Reported and Belief in Charisma

Belief in the sanctity of god-men and their charisma is analysed with the persons who suffer from diseases in Table-4.21. Users who believe that god-men can cure diseases comprise 13 per cent of those belonging to the chronic disease category and another 13 per cent from the category believe in the divine power of god-men, while it is 11 and 10 per cent of the total in acute disease category, respectively.

Table-4.21 Persons with Various Diseases and Belief in Charisma N=91

Disease	Acute	Injury	Chronic	Mild
Divine power	9 (32)	4 (20)	12 (39)	3 (25)
Cure diseases	10 (36)	8 (40)	12 (39)	7 (58)
Ordinary human	3 (11)	3 (15)	3 (10)	1 (8)
Business	6 (21)	5 (25)	4 (14)	1 (8)
Total	**28**	**20**	**31**	**12**

Source: Data collected in fieldwork during 2018 June-Jan 19

From 36 to 58 per cent of the care receivers in each disease category believe that god-men can cure disease. It includes all four categories of illnesses in which persons with the mild illness have the highest share (58%) in the belief and the category of injury shares 40 per cent, 39 per cent of users with chronic diseases and 36 per cent of users with acute diseases share the belief. Every second or third user believes in the gurus' sanctity of curing diseases.

Respondents consider god-men as ordinary human beings, ranging from eight to 15 per cent from mild to injury categories of diseases. At the same time, care users who treat god-men as business persons range from eight to 25 per cent within the category (Table-4.21). That is, persons suffering from any disease believe in the sanctity of curing diseases rather than the divine power of god-men.

Occupation and Belief in Charismatic Power

Table-4.22 considers the occupation of the respondents and their belief in the charismatic power of god-men. From the table, 55 per cent of government employees, 50 per cent of businesspeople and 47 per cent of private employees believe that god-men can cure diseases. They believe in the divine power of god-men with a share of 27, 42 and 33 per cent,

respectively. Interestingly, 43 per cent of labourers believe that god-men are ordinary humans and another 43 per cent consider it a business.

Table-4.22 Belief in Charisma and Occupation of the Respondents

Occupation	Divine power	Cure diseases	Ordinary human	Business	**Total**
Government employee	3 (27)	6 (55)	0	2 (18)	**11**
Private employee	10 (33)	14 (47)	3 (10)	3 (10)	**30**
Business	5 (42)	6 (50)	1 (8)	0	**12**
Labour	1 (14)	0	3 (43)	3 (43)	**7**
House wife	6 (30)	7 (35)	2 (10)	5 (25)	**20**
Student	3 (50)	1 (17)	1 (17)	1 (17)	**6**
Retired	0	3 (60)	0	2 (40)	**5**

Source: Data collected in fieldwork during 2018 June-Jan 19

Conclusion

Evidence from the field proves that philanthropic institutions providing healthcare services based on a tag of 'non-profit' and 'charity' are merely a legal entity than a philosophical way of doing charity. They enjoy the benefit of the 'charity' tag in diverse manners by providing nominal healthcare services to a few. These services are a part of a mandatory academic activity called outreach work of the students, where they extend help to the villagers far from the hospitals. The big institutions relocated their area of operation geographically from their birthland to more urbanised places and the centre of healthcare hubs. Three out of four users who access these hospitals have urban or town-centred residence. The residing location of respondents is either a municipality or a corporation. It indicates that they are more developed than the people from village-Panchayat. In economic terms, philanthropic organisations' 'geographical relocation' is a market expansion for selling healthcare goods.

However, diverse people access healthcare services, including people from various religious groups. The social and geographical locations of the institutions attract a wide variety of people from their vicinity. More than half of the beneficiaries coming to particular hospitals are within 20 kilometres of distance from it. People belonging to the same social identity as that of an institution are comparatively more inclined to the institution due to the demography of that geographical area. However, socially and educationally forward castes share sixty per cent of the total users. The location chosen by any organisation to build a hospital is a significant factor in attracting many people. It also helps to distract some of the weaker sections

of society from accessing the services. The term ‘access’, for these organisations, has a specific connotation in terms of transportation to reach the hospital that never includes the socio-economic factors pinned with the term. Hence, they provide a map to reach the hospital by road, rail, or air for foreign beneficiaries. As a result, users from oppressed sections like Scheduled Tribe (ST) cannot access it and other weaker sections are comparatively less in the institutions.

The philanthropic hospitals provide techno-centric tertiary-care services with modern facilities mainly for diagnosis and treatment of Non-Communicable Diseases (NCD). Half or one-third of the users diagnosed with NCD access these hospitals where acute and chronic diseases hold the highest share. Male users are higher in number than females in this disease category and in general. As per the analysis, older people in Kerala are at stake due to these diseases and they comprise a more significant share among users. The hospitals flag the tag of ‘special care’ for the older population without any healthcare insurance coverage. People diagnosed with acute or chronic diseases spend an average of INR 17,500 for the treatment and every fourth person with the same disease spend an average of INR 50,000. Only 25 per cent of the users enjoy the relaxation in cost.

The analysis of the social and economic background of the beneficiaries draws another aspect of the study. Care receivers with middle-level education attainment comprise the highest part, and a considerable share of higher-educated people is there. People with lower-level education attainment are insignificantly small in number among the respondents. In addition, half of the beneficiaries have prosperous jobs in either government or private sectors. Labourers or daily wagers could not afford the cost of a technology-driven treatment in a philanthropic hospital. Hence, higher and middle-income families constitute more than 90 per cent of the total beneficiaries and lower-income families are less attracted to these hospitals except in the case of any critical condition. Even though the selected institutions are philanthropic care centres, every third user is indebted due to the cost of care. Three out of four users have the privilege of higher education, caste, high income, land, and assets. Those who are less privileged are pulled back from accessing these institutions.

Various push factors in the selection of a philanthropic care centre over government and private hospitals can be found. One-third of the users have left public hospitals due to the lack of facility and long waiting for their turn and choose philanthropic care. Every fourth user is attracted to the hospital due to doctors' charisma, and every second user accesses it due to

the institution's proximity. People diagnosed with NCD and emergency due to injury choose philanthropic hospitals than those coming for mild ailments. Hence, the charisma of the doctor is a marketing tool that the hospital administration utilises.

Similarly, some hospitals are famous for diagnosing and treating complicated health conditions with the help of ‘advanced’, ‘modern’ ‘technology’, which is termed ‘facility’ by the beneficiaries. It also attracts them to the hospitals. In short, the selection is not based on charity entities, but beneficiaries seek ‘best care’ from the ‘best place’.

The religious and caste-based philanthropic institutions have better scope in a society where caste and religion have been used to grade individuals. The ‘charismatic’ spiritual leaders behind the charity activities influence society largely. The degree of religiosity of beneficiaries of philanthropic hospitals points out that god-men and spiritual gurus expand their empire by exploiting the belief. Every second care receiver strongly believes in God-men's ‘divine charisma’ despite the varying degree of their religiosity ranging from religiose to not religious. Similarly, thirty per cent of people believe that Godmen/women cure diseases. The followers of a spiritual guru are from the creamy layer of the society that includes government employees and business people. Individuals with financial prosperity are comparatively more attracted to god-men and on the other hand, those who live in distressed conditions invoke a ‘divine protection’ of gurus. Younger individuals tend to reject the sanctity of gurus, whereas they are susceptible to the ‘ecstatic state’ of gurus when getting older. The ‘aura’ created by gurus’ ‘spiritual realm’ is potent, controlling even a non-religious person.

Chapter 5

Evidence from the field: Analysis of Medical Education in Philanthropic Institutions in Kerala

This chapter deals with one of the research objectives regarding medical education provided by the philanthropic foundations in Kerala. It reflects the interactions between students and philanthropic institutions. Table-5.1 illustrates the total respondents comprising 92 medical students from these institutions. The chapter also focuses on the fee structure of philanthropic medical education, students' composition, and their social demographic environment.

The students are from MBBS and other medical courses offered by the selected three medical colleges. Students from diverse social and economic backgrounds have responded, which enriches the study analysis. While considering the religious association, students from every major religious group in the state has been included from each institute. However, the researcher could not include students from the most deprived social categories like scheduled tribes and Dalits due to the paucity of such respondents. It may reflect in the analysis as a limitation. It shows the economic disadvantage of these groups in accessing medical education from sophisticated philanthropic institutes. In another way, philanthropic organisations are yet to be developed to accommodate deprived sections in their institutes. Since the selected institutes have different reputation levels in the society, students in each institute have specific social locations, which we shall discuss in detail in the coming sections. Similarly, the geographical locations of the institutes, which are different from that of the mother organisations, bring forth some implications.

Table-5. 1 Overall Respondents among Medical Students N=92

Sex	Male	41 (45)
	Female	51 (55)
Religion	Christian	27 (29)
	Hindu	39 (42)
	Islam	26 (28)
Social Category	General	56 (61)
	OBC	28 (30)
	SC	8 (9)

Source: Data collected in fieldwork during 2019 Jan-March

Socio-demographic Profile of the Respondents

Overall, 92 respondents from medical institutions run by philanthropic foundations are given in Table-5.1. It is observed from the table that female respondents are in the higher share, which constitutes 55 per cent of the total; girls are more attracted to medical education. The religious composition indicates that Hindus contribute 42 per cent, while Christians and Muslims are 29 and 28 per cent, respectively. There is much difference in the share among these groups. Out of the total students, 61 per cent belongs to the general category, while Scheduled Caste constitutes only nine per cent. Other Backward Castes (OBC) represent 30 per cent. It indicates that students from socially and educationally forwarded groups are sheer constituents in medical education, while vulnerable caste groups have been underrepresented.

Table-5. 2 Religious Composition of Students in Different Institution (% within the religious groups) N=92

Institution	Christian	Hindu	Islam	**Total**
A	5 (19)	19 (49)	7 (27)	**31**
B	17 (63)	9 (23)	5 (19)	**31**
C	5 (19)	11 (28)	14 (54)	**30**
Total	**27**	**39**	**26**	**92**

Source: Data collected in fieldwork during 2019 Jan-March

The religious composition of students in each institution is given in Table-5.2. It is observed from the table that each institution has a particular religious concentration of students. Muslim students are the highest in number in the institution run by Muslim management (Inst-C), which comprises 54 per cent. Hindus and Christians constitute 49 and 63 per cent of the institutions managed by Hindus (Inst-A) and Christians (Inst-B), respectively (Table-5.2). Muslim students are the second largest population in these two institutions.

Table-5. 3 Social Category in Various Institutions N=92 (% within the institution)

Institution	General	OBC	SC	**Total**
A	22 (71)	8 (26)	1 (3)	**31**
B	17 (55)	9 (29)	5 (16)	**31**
C	17 (57)	11 (37)	2 (7)	**30**

Source: Data collected in fieldwork during 2019 Jan-March

We can observe from Table-5.3 that 71 per cent of the students in Institution-A belong to the general category and students from scheduled caste (SC) represent only three per cent. Sixteen per cent of students from SC are in Institution-B, which is the highest share among the

three. OBC category shares 26, 29 and 37 per cent in Institution-A, B and C, respectively. One out of four or three students is from OBC groups in every institution. However, the general category comprises more than half of the total students in each institute.

Table-5. 4 Respondents' Religion and Social Category N=92 (% within the religion)

Religion	General	OBC	SC
Christian	12(44)	11(41)	4(15)
Hindu	32(82)	3(8)	4(10)
Islam	12(46)	14(54)	00
Total	**56(61)**	**28(30)**	**8(9)**

Source: Data collected in fieldwork during 2019 Jan-March

Table-5.4 shows that 82 per cent of Hindu religion respondents are from the general category and only eight per cent belong to the OBC category. Scheduled Caste (SC) constitutes ten per cent of Hindu religion and 15 per cent of Christian. It is evident from the table that the representation of weaker sections of the Hindu religion is miserably poor in medical education, while students belonging to the OBC category from Christian and Muslim communities are higher in number in medical institutions. Christian OBC has 41 per cent and Muslims have 54 per cent, which is highest in the total and greater than the Muslims' General category.

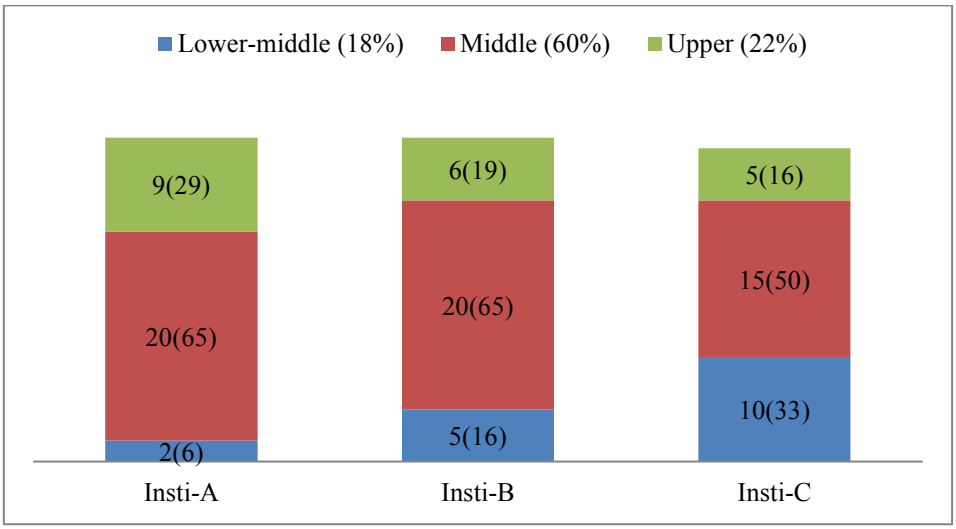
Economic Characteristics and Assets owned by the Respondents

Figure-5.1 represents the family income of the respondents. It is categorised into Lower-middle, Middle and Upper-income groups. The Lower-middle (LM) income family earns up to INR 30,000 (including) per month, whereas Middle and Upper-income families earn more than INR 30,000 to 42,000 and above 42,000 per month, respectively. The LM income families constitute 18 per cent, middle and upper-income families comprise 60 and 22 per cent of the total respondents, respectively. Middle-income families are concentrated mainly in medical colleges run by philanthropic foundations.

When analysing Figure-5.1, it is revealed that there is a large concentration of middle and upper-income groups in all three institutions. The middle-income group (INR 30,000 to 42,000) includes 65 per cent of the students in Institution-A and B, whereas Institution-C has 60 per cent of students from the same income group. The students from Lower-middle income (INR <30,000) families constitute only six per cent in Institution-A and 16 per cent in Institution-B. One out of three students in Institution-C belongs to lower-middle-income

families. The figure shows that 82 per cent of the medical students have a sound economic background (Figure-5.1).

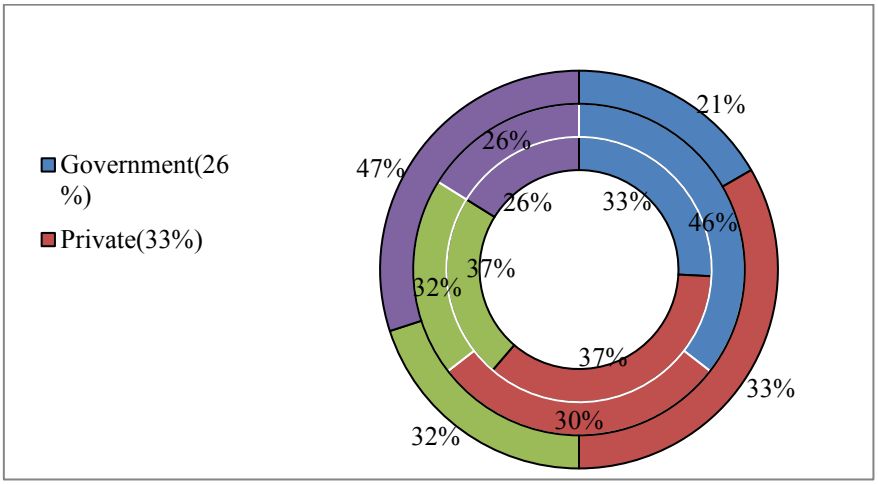
Figure-5. 1 Categories based on Monthly Family Income N=92 (%)



Source: Data collected in fieldwork during 2019 Jan-March

Figure-5.2 represents the institution wise guardians' job in which Government, Private, Business and Others categories are given. Predominantly, 33 per cent of guardians are in private sector jobs and 26 per cent are in government jobs. The business sector comprises 21 per cent of the jobs and 'Others' also shares the same. It means that elite sections of the society are primarily attracted to medical education while 'Others' comprises nearly one out of four students.

Figure-5. 2 Guardians' Job



Source: Data collected in fieldwork during 2019 Jan-March Remarks: Inner circle represents Institution-A, Middle circle- Institution-B and Outer circle- Institution-C

While analysing the institution wise data, guardians who have government jobs are highest in Institution-B with a 46 per cent share. Institution-A has the highest share of guardians who are into business and working in the private sector, constituting 37 per cent for each. Others are highest in Institution-C with a share of 47 per cent (Figure-5.2).

Figure-5.3 shows the most common assets of students in the three institutions. Every second out of three students have their car, which is 65 per cent of the total medical students. Sixty-seven per cent of students in Institution A, 61 per cent in Institution B, and 68 per cent in Institution C have their car. The remaining students in these institutions own motorcycles.

Figure-5. 3 Assets of Respondents

Source: Data collected in fieldwork during 2019 Jan-March

Caste Affiliations of the Respondents

Table-5.5 shows the composition of the caste of the students in each institution. The reported caste is broadly categorised into Forward and Backward Castes, based on the State's social, educational, and economic conditions. The total number of respondents is 64 who belong to any castes from either Hindu or Christian religion. Muslims and two Christian respondents claimed that they have no caste. Hence, they are omitted from the total 92.

Table-5. 5 Forward and Backward Castes in the Institutions N = 64 (% within the institution)

Institution	FC	BC
A	16 (70)	7 (30)
B	14 (54)	12 (46)
C	11 (73)	4 (27)
Total	**41 (64%)**	**23 (36%)**

Source: Data collected in fieldwork during 2019 Jan-March

It is observed from Table-5.5 that 64 per cent of the students are from the Forward Castes (FC). Institution-C has the lowest share (27%) of Backward Castes (BC), while Institution-B has a comparatively better representation of the BC (46%) among other institutions. Institution-A has only 30 per cent of BC students (Table-5.5). Despite the constitutional mandate of the reservation to ensure the representation of vulnerable sections in educational institutions, their number remains low than the desired level.

Table-5. 6 Forward and Backward Castes in the Religious groups (Percentage within the religion) N=92

	FC	BC	No Caste	**Total**
Christian	12(44)	13(48)	2(8)	**27**
Hindu	29(74)	10(26)	0	**39**
Islam	0	0	26	**26**
Total	**41**	**23**	**28**	**92**

Source: Data collected in fieldwork during 2019 Jan-March
Remarks: FC- Forward Caste, BC- Backward Caste

When we analyse students belonging to forward and backward castes with respect to their religion (Table-5.6), it is observed that 74 per cent of the students from the Hindu religion belong to Forward Castes (FC). The students from Backward Castes are 48 per cent among Christians, which are slightly higher than the FC representation. It is noticeable that a large section of students belonging to BC in the Hindu religion is out of philanthropic medical institutions. They could not access these institutions not only because of their poor economic condition but also because of their caste identities.

Land Ownership and Caste

Respondents belonging to forward and backward castes are divided into three groups based on the land ownership of the respondent's family, which is given in Table-5.7. One of the groups is 'Lower middle' (LM) who owns up to ten cents of land (100 cents is one acre), another group is 'Middle' who owns the land between 10 to 20 cents, and the third group is 'Upper' who owns more than 20 cents of land. Respondents who claimed to have 'No Caste' are also added in the column of 'Caste'; they are mostly Muslims (Table-5.7).

The LM category families comprise 27 per cent of the total students, middle and upper categories constitute 50 and 23 per cent, respectively. Respondents from Forward Caste (FC) are 41 and Backward Caste (BC) are 23 and 28 respondents did not have caste. Students from

the Middle category constitute half of the total in both FC and BC groups. LM category constitutes 22 per cent in the BC and 20 per cent in FC.

Table-5. 7 Land ownership of Forward and Backward Caste Groups (Percentage within the caste) N=92

Caste-Land	LM	Middle	Upper	**Total**
Forward	8(20)	22(54)	11(27)	**41**
Backward	5(22)	13(57)	5(22)	**23**
No Caste	12(43)	11(39)	5(18)	**28**
Total	**25(27)**	**46(50)**	**21(23)**	**92**

Source: Data collected in fieldwork during 2019 Jan-March
Notes: LM: Lower middle- land ownership ≥10; Middle- 10-20; Upper- 20<

However, 43 per cent of respondents from the No Caste group belong to the LM category in terms of land ownership. The majority of the students belong to the Middle and Upper categories, which cumulatively constitute 73 per cent of the total (Table-5.7).

Table-5.8 categorises three types of respondents from each institute based on the size of land owned by the respondents' families. These categories are 'Lower Middle' (LM), who owns up to ten cents of land, Middle (owns 10 to 20 cents), and Upper (owns more than 20 cents). Middle constitutes 45 per cent of the total students in Institution-A and LM constitutes 39 per cent. Institution-B has students from the Middle (61%) and Upper (39%) categories, but the LM category is zero. LM category is highest in Institution-C compared to other institutions with a 43 per cent share.

Table-5. 8 Land Ownership of Respondents from Various Institutions (Percentage within institution) N=92

Land	LM	Middle	Upper	**Total**
Inst A	12(39)	14(45)	5(16)	**31**
Inst B	0	19(61)	12(39)	**31**
Inst C	13(43)	13(43)	4(14)	**30**
Total	**25**	**46**	**21**	**92**

Source: Data collected in fieldwork during 2019 Jan-March
Note: LM: Lower middle- land ownership ≥10; Middle- 10-20; Upper- 20<

Table-5.8 indicates that students from Middle-class families are more attracted to medical education provided by these foundations and the Upper category is less attracted to it than the Lower Middle category.

Table-5. 9 Income Categories in Caste Groups N=92 (% within the income groups)

Income	FC	BC	No Caste	**Total**
LM	3(18)	6(35)	8(47)	**17**
Middle	31(56)	13(24)	11(20)	**55**
Upper	7(35)	4(20)	9(45)	**20**

Source: Data collected in fieldwork during 2019 Jan-March

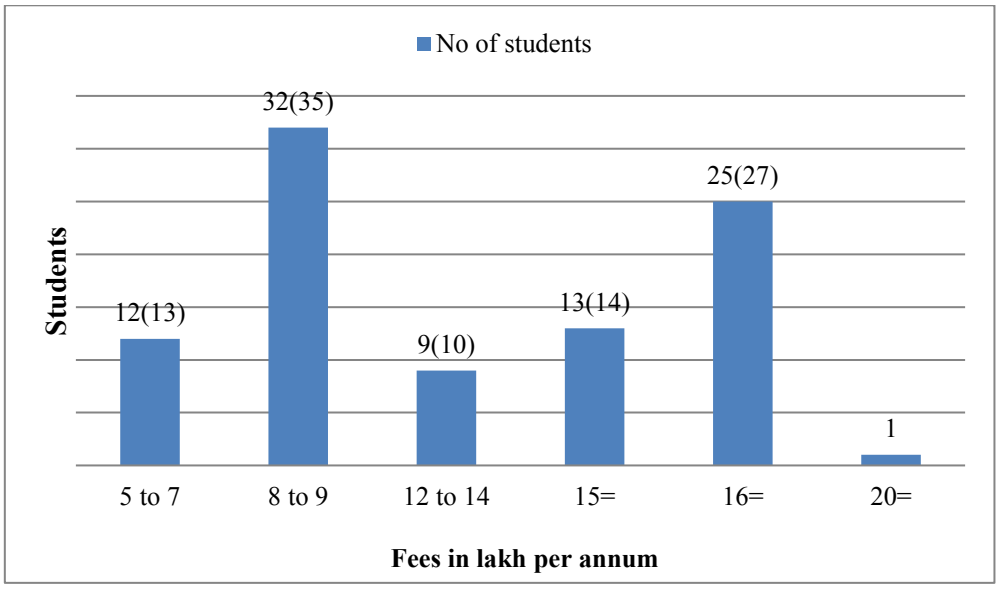
Note: FC- Forward Castes, BC- Backward Castes and LM- Lower middle

As we divided earlier, Table-5.9 includes three income categories and two caste groups. Forward castes (FC) constitute 18 per cent of the LM category and BC constitutes 35 per cent. In middle-income families, 56 per cent belongs to FC and 24 per cent belongs to BC. The FC share in upper-income families is 35 per cent and BC is 20 per cent. It is observed from Table-5.9 that students from middle-income families with caste privileges are highly concentrated than others in these institutions.

Annual Medical Fees in Philanthropic Institutes

The Figure-5.4 shows the annual fee for medical education paid by students in the three institutions ranging from five lakh Indian rupees to 20 lakhs. The variance is due to 'quota' seats in institutions where merit, management and NRI fees are different. However, students from these quotas pay higher fees than the standard fixed by the State Government. The standard annual medical education fees for merit quota is INR 5 lakhs, for management quota is INR 10 to 14 lakh and for NRI quota, it is higher than 14 lakh per annum.

Figure-5. 4 Fee for Medical Education (in lakh per annum) N=92

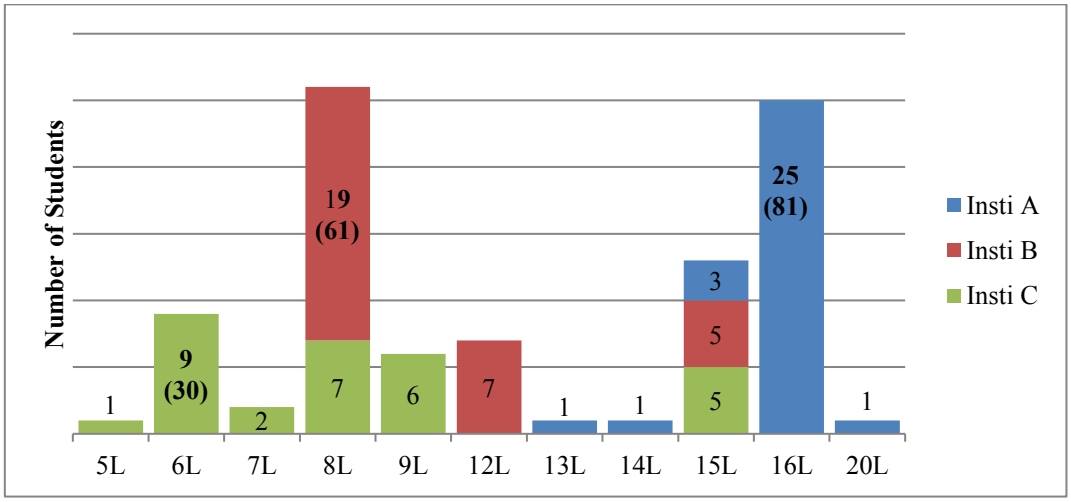


Source: Data collected in fieldwork during 2019 Jan-March

In Figure-5.4, 35 per cent of students pay INR eight to nine lakhs per annum and 27 per cent of students pay INR 16 lakhs. Only 13 per cent of the students pay five to seven lakhs, ten per cent pay 12 to 14 lakhs and 14 per cent pay 15 lakh rupees per annum. It is observed from the figure that these institutions incurred on an average of more than 15 lakh rupees per seat in a year. The figure indicates an inconsistency in the fees levied by the medical colleges run by philanthropic foundations (Figure-5.4).

Figure-5.5 represents the fee for medical education for a year in various institutions. The number of students is on the Y-axis, the annual fee in lakh is on the X-axis, and each institution is separated with different colour labels. Students paying 16 lakhs constitute 81 per cent and no students pay less than 13 lakh per annum in Institution-A.

Figure-5. 5 Annual Fee for Medical Education in various Institutions N=92 (%within the institution)



Source: Data collected in fieldwork during 2019 Jan-March

At the same time, 61 per cent of students pay eight lakh and 23 per cent pay 12 lakh rupees per year in Institution-B. Similarly, 30 per cent of students pay six lakh and 17 per cent pay 15 lakh rupees in Institution-C. It shows that medical education is most expensive in philanthropic institutions, much more than the standardised fees and Institution-A levies the highest annual fee from students among other institutions (Figure-5.5).

Table-5.10 shows the quota-based fee for medical education in the three institutions. The quota fees in one institution are categorised into three; <nine lakhs per annum for merit-based seats, 9 to 14 lakhs for management seats and 14< lakhs for NRI seats. In general, 41 per cent of the students belong to the merit quota, 15 per cent belongs to management and 43 per

cent belongs to the NRI quota. In merit seats, two types of fee structure can be seen in these institutions, that is 68 per cent of students within the merit quota pay 7 to 9 lakh rupees per year and the remaining students pay 5 to 7 lakh rupees per year.

Table-5. 10 Quota-based Fee for Medical Education N=92

Fee (in lakh)	Quota			Total
	<9 Merit	9 – 14 Management	14< NRI	
5-7	12	0	0	12
<9	26	0	0	26
9-13	0	14	0	14
14	0	0	1	1
15	0	0	13	13
16	0	0	25	25
20	0	0	1	1
Total	**38(41)**	**14(15)**	**40(43)**	**92**

Source: Data collected in fieldwork during 2019 Jan-March

Note: It is not reflecting the composition of students from a single institute

At the same time, in the NRI quota, four types of fee structures are reported, which are 14, 15, 16 and 20 lakh rupees per year. Here, 63 per cent of the students reported that they pay 16 lakh and 33 per cent said they pay 15 lakh rupees per year and one student pays 20 lakh rupees per year, which is the highest paid seat. There is evident inconsistency in fee structure within the institution and within the quota seats (Table-5.10).

Scholarship Assistance for Medical Students

When medical education is costly at colleges run by philanthropic organisations, provisioning scholarships for students is much-needed assistance. Table-5.11 shows the provisioning of scholarships for the students who get admission in any of the quota seats.

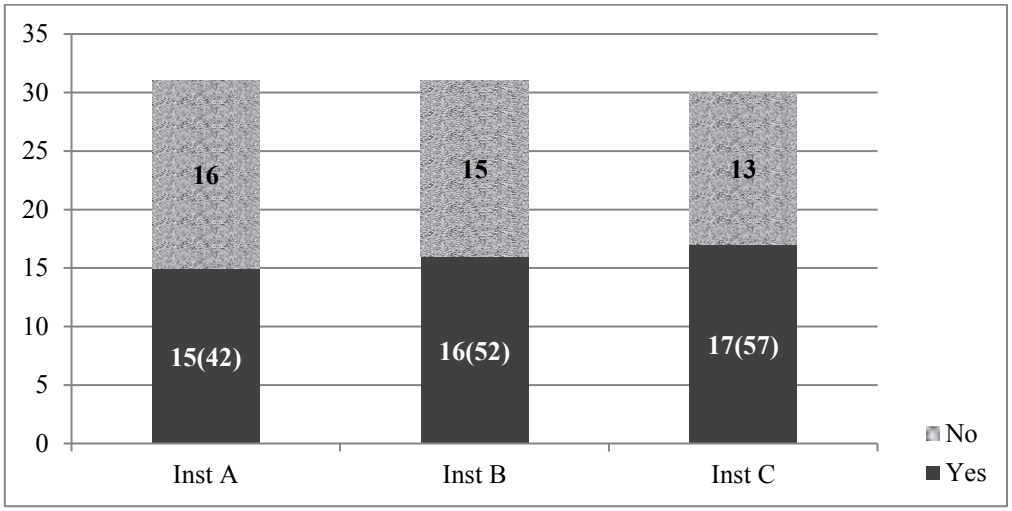
Table-5. 11 Provision of Scholarship for Medical Students in Different Quotas N=92 (% within the quota)

Scholarship	Yes	No	Total
Merit	26(68)	12(32)	38
Management	7(50)	7(50)	14
NRI	15(38)	25(62)	40
Total	**48(52)**	**44(48)**	**92**

Source: Data collected in fieldwork during 2019 Jan-March

It is evident from Table-5.11 that 52 per cent of the total students (N=92) get scholarships though 48 per cent are out of any assistance. Among the 38 students who got admission in the merit quota, 68 per cent are beneficiaries of scholarship assistance. However, one out of every three students in the merit quota does not get any assistance. Similarly, every second student in the management quota has no scholarship assistance and two out of three students in the NRI quota have no scholarship. It indicates that 48 per cent of the medical students in philanthropic institutions do not have scholarship assistance despite the higher annual fee (Table-5.11).

Figure-5. 6Scholarship Assistance in various Institutions N=92 (% within the institution)

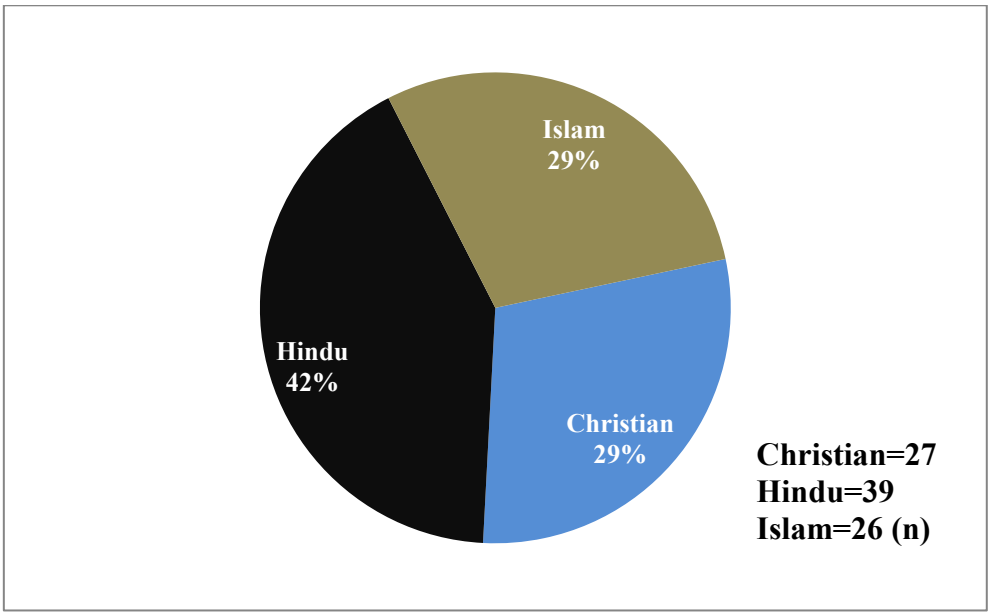


Source: Data collected in fieldwork during 2019 Jan-March

Figure-5.6 shows that Institution-A provides scholarships to 42 per cent of the students, which is the lowest among the three. Institution-B provides to 52 per cent of the students, which is slightly higher and Institution-C provides to 57 per cent of students; the highest among the three institutes. Half of the medical students are not receiving any scholarship assistance from philanthropic institutions.

Table-5.7 points to the religious composition of the scholarship beneficiaries. Among the 92 respondents, 48 students receive a scholarship from religious groups in which 42 per cent belongs to Hindu and 29 per cent belongs to Muslims and Christian religious groups independently.

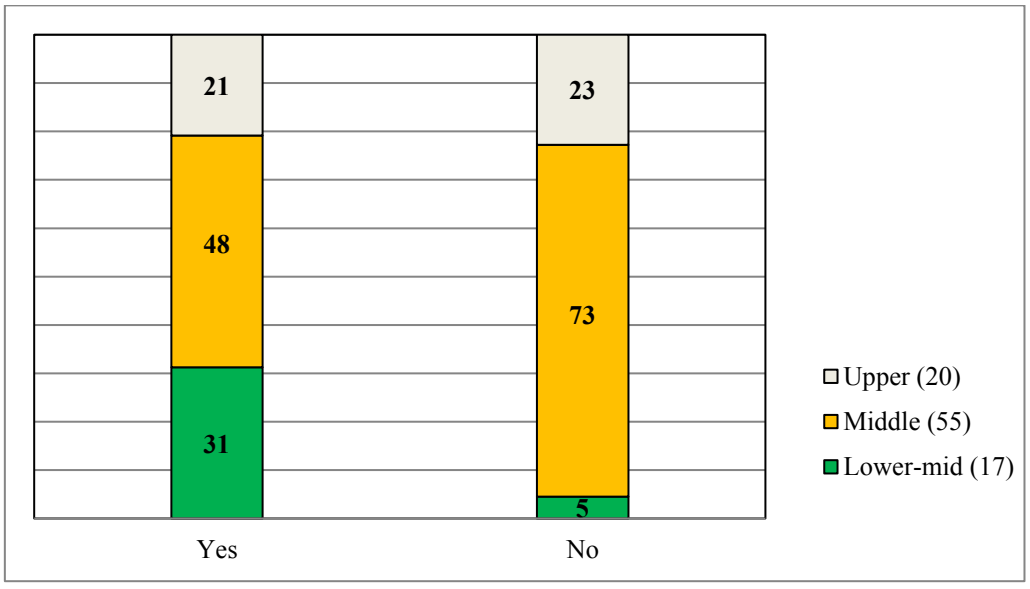
Figure-5. 7 Religious composition of Scholarship Beneficiaries (% within scholarship)



Source: Data collected in fieldwork during 2019 Jan-March

At the same time, religious group based data shows that more than 50 per cent of students from each religious group are beneficiaries of the scholarship. It is 52, 51 and 54 per cent for students in Christian, Hindu and Islam, respectively.

Figure-5. 8 Income Categories among Scholarship Beneficiaries N=92 (% within scholarship)



Source: Data collected in fieldwork during 2019 Jan-March.

Note: Lower-middle= <30,000 pm Middle=30-40,000 Upper=40,000<

When analysing scholarship beneficiaries, Figure-5.8 indicates that students from middle-income families benefit more from the scholarship schemes than lower-middle-income

families (Figure-5.8). They constitute 48 per cent of the beneficiaries and students belonging to lower-middle-income families constitute 31 per cent of the total scholarship beneficiaries. Students from upper-income families constitute 21 per cent of the beneficiaries. At the same time, 73 per cent of the students from middle-income families study without scholarship assistance.

However, while we analyse the economic groups independently, it can be observed that 88 per cent of the students from lower-middle-income families receive scholarship assistance (Figure-5.8).

Table-5. 12 Sex Composition of Scholarship Beneficiaries

(% within the sex category)

Scholarship	**Yes**	**No**
Male	25(52)	16(36)
Female	23(48)	28(64)
Total	**48**	**44**

Source: Data collected in fieldwork during 2019 Jan-March

Table-5.12 represents sex categories of scholarship beneficiaries in which 52 per cent are male students among those who receive a scholarship and the remaining share denotes female beneficiaries. However, 68 per cent shares in the case of students who do not get a scholarship are females, which are far higher than the share of male students. More female students are out of the benefit than males (Table-5.12). The inference from these tables and figures on scholarship proves that the criterion to provide scholarship to students is unscientific. These institutions do not correctly identify the vulnerability of a student for assisting in their studies.

Medical Students Approach for Bank Loans

Table-5.13 shows that 80 per cent of the medical students are holders of interest-bearing education loans. In addition, 92 per cent of students within the merit quota are forced to take bank loans. Three out of four students in the management and NRI quota, constituting 71 and 73 per cent within the quota, respectively, also receive interest-bearing loans (Table-5.13). The quota difference does not reflect among students in the case of loan liability that results in profit-oriented healthcare services. It also means that 80 per cent of the medical professionals in philanthropic institutions become financially indebted to money-lending banks soon after graduation.

Table-5. 13 Students Approaching Banks for Education Loan

N=92 (% within the quota)

Quota	Loan	No
Merit	35(92)	3
Management	10(71)	4
NRI	29(73)	11
Total	**74(80)**	**18**

Source: Data collected in fieldwork during 2019 Jan-March

Education loan holders are divided based on three income categories in Table-5.14. It is observed that 94 per cent of students from lower-income and 84 per cent from middle-income families are education loan holders. It is 63 per cent in upper-income families. In the case of students who receive the interest-bearing loan (N=74), students from middle-income families are the largest holders of interest-bearing loans that constitute 62 per cent, followed by 20 per cent of students from the lower-income category.

Table-5. 14 Income Categories of Education Loan Holders N=92 (within income)

Income/Loan	Yes	No	Total
Lower	16(94)	1	17
Middle	46(84)	9	55
Upper	12(63)	8	20
Total	**74**	**18**	**92**

Source: Data collected in fieldwork during 2019 Jan-March

Table-5.15 refers to the caste categories of loan holders among medical students in philanthropic institutions. According to the table, 85 per cent of the students who belong to Forward Castes (FC) have taken bank loans and 87 per cent of students from Backward Castes (BC) are holders of the interest-bearing loan that is slightly higher than FC.

Table-5. 15 Caste Categories of Loan Holders among Medical Students

(% within the caste group)

Loan	FC	BC	NC	Total
Yes	35(85)	20(87)	19(68)	74
No	6	3	9	18
Total	**41**	**23**	**28**	**92**

Source: Data collected in fieldwork during 2019 Jan-March

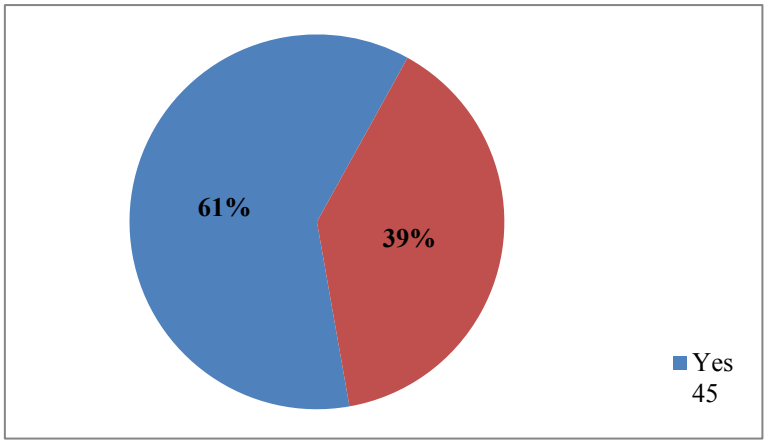
Note: FC- Forward Caste BC- Backward Caste NC-No Caste

However, students who do not have a caste constitute 68 per cent within NC. When considering total loan holders (N=74) among medical students, FC constitutes 47 per cent

(Table-5.15), which means the economic burden of medical education severely affect a higher segment of the society.

Figure-5.9 shows that 39 per cent of the loan holders do not get any scholarship assistance for their medical education. It results in bearing a higher loan amount from the banks that will be a double burden on them.

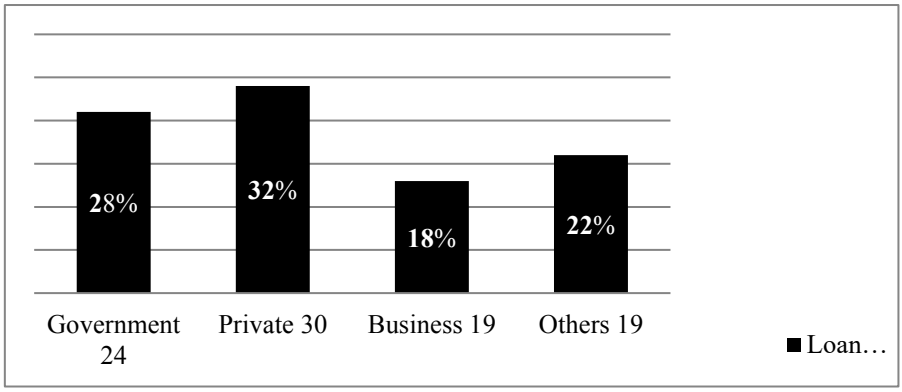
Figure-5. 9 Loan Holders Getting Scholarship (N=74)



Source: Data collected in fieldwork during 2019 Jan-March

Figure-5.10 represents the composition of loan holders based on the job of their guardians. In this figure, 32 per cent of guardians work in the private sector, followed by 28 per cent in the government sector. Guardians who are into business are the lowest among the loan holders.

Figure-5. 10 Loan Holders based on Guardians' Job (N=74)



Source: Data collected in fieldwork during 2019 Jan-March

However, guardians who have a government job constitute 88 per cent, which is the highest within the job categories. Eighty-four per cent of students in the category of 'Others' also take an interest-bearing loan.

It means that medical fees in these institutions create financially indebted people from two extreme sections of society. One section has unstable jobs in creating income and earnings and another one has 'Government' jobs that are considered secure. However, both fall in the same basket of indebtedness while considering education loans.

Table-5. 16 Religion of the Loan Holders (N=74)

	Religion (% within religion)		
Loan	Christian	Hindu	Islam
Yes	**20(74)**	**37(95)**	**17(65)**
No	7	2	9
Total	27	39	26

Source: Data collected in fieldwork during 2019 Jan-March

According to Table-5.16, 95 per cent of students from the Hindu religion and 74 per cent from the Christian religion take bank loans. Students belonging to the Islam religion are comparatively less attracted to interest-bearing education loans, which constitutes 65 per cent within the 'Islam' group. However, it is observed that more than half of the students from any religion approach for bank loans and students from Hindu religion constitute the highest share among all (Tabl-5.16).

Table-5. 17 Sex Composition of Loan Holders

	Sex		
Loan	Male	Female	N=74
Yes	**34(46)**	**40(54)**	**74**
No	7	11	18
Total	41	51	92

Source: Data collected in fieldwork during 2019 Jan-March

Table-5.17 points out that 54 per cent of the loan holders are female students and male students constitute 46 per cent of the total loan holders. Female students are financially more indebted to banks when compared to male students in philanthropic institutions.

Table-5. 18 Distance from Students' Hometown to Reach the Institute

Institution	**Distance to reach the institute in KM N=92**		
	<30	**31-70**	**70<**
A	4(18)	18(35)	9(47)
B	12(55)	16(32)	3(16)
C	6(27)	17(33)	7(37)
Total	**22(24)**	**51(55)**	**19(21)**

Source: Data collected in fieldwork during 2019 Jan-March

Table-5.19 represents the distance from students' hometown to reach the medical institute. The categorisation is based on the average distance to reach the institute from the adjacent district. Students who come from within 30 kilometres constitute 24 per cent, between 31-70 kilometres constitute 55 per cent and above 70 kilometres constitute 21 per cent of the total. More than half of the students come from the second distance category.

Institution-B has the highest number of students coming from within 30 km, constituting 55 per cent within the distance category. Institution-A and C have the highest number of students who come from more than 70 km, which constitutes 47 and 37 per cent respectively in the distance category (Table-5.19).

Conclusion

Medical education provided by these three philanthro-capitalist foundations produce more than 300 graduates every year and it crosses 6000 when considering all the institutes in Kerala. More than half of the medical graduates are females, more attracted to medical education than males. Each philanthropic institute is solely based on religious identity and students from those particular religious groups have the highest share in respective institutes. However, vulnerable sections from these religious groups do not get adequate representation in medical education due to the skyrocketing fee structure. Though oppressed caste sections are severely under-represented, students from religious minorities have equal or more share in every institution. Among the caste groups, students from Forward castes occupy 2/3rd of the seats in philanthropic medical institutions.

Medical education from philanthro-capitalist institutions has become more and more attractive to middle and upper-income and forward caste families. It is due to multiple reasons, including the highly expensive fees for medical education, which pull back lower-income families. At the same time, upper-income families believe that a doctor in the family is helpful

to acquire social status. Hence, they spend money to grab a medical seat in the management quota in these colleges. However, graduates become indebted to huge interest-bearing loans after their education, irrespective of economic and social conditions. These institutions do not have a standardised fee structure based on the state medical education board. It ranges from five lakh rupees to twenty lakh per annum in merit, management and NRI quotas. Middle-class families are ready to spend millions of rupees for a graduate seat in medical institutes to maintain or acquire the status of a 'doctor family'. As a result, these institutions sell medical seats with maximum profit corresponding to the candidate's rank. It means that there is reciprocity between middle-class society and these philanthro-capitalist institutions that demand mutual existence to cater to their needs.

Educational scholarships mitigate the economic burden to a small extent to half of the total students. However, the remaining half does not have any scholarship assistance to complete the study. Middle-class students benefit more from scholarships than the weaker students, which shows the absence of systematic identification of vulnerability and distribution of scholarship among students. When students are indebted to banks for interest-bearing loan repayment, their burden doubles if no scholarship is provided. Female medical graduates are more vulnerable to bank loans and face more mental stress for repayment. The situation is such that medical education cannot be completed without the support of substantial bank loans, even if the students have a sound economic background, land ownership and caste privilege.

Medical institutes run by philanthropic foundations cater for the needs of wealthy and forward caste families. Along with this, the religious identities of these institutes attract students from their respective religious groups. As a result, the foundations are the saviour of the upper ladder of the society who are never aware of the ideology of philanthropy and capitalism. Hence, both sections serve for the mutual existence and keep the relation of a buyer and seller.

Chapter 6

Authority and Legitimation in Religion and Caste-based Philanthro-capitalist Foundations in the Light of Weberian Theory

The earlier idea of charity was replaced by philanthropy during the industrial revolution. When states focused on implementing neoliberal policies across the world, philanthropy gradually turned into a profit-oriented business. Then philanthro-capitalism emerged as a 'magic tool' to solve social problems through business means. Philanthro-capitalism is a profitable business in the guise of charity and a way of legitimising the foundations' power and authority. Globally, these foundations became the most influential bodies in policymaking for various international programmes. This section deals with the exercise of social identities by philanthropic organisations to influence the masses and augment private wealth. Weberian theory on power and authority facilitates the analysis of the features of these foundations and the exercise of power in the context of Kerala. For analysis, the researcher used case studies, field observation, and former interviews of the various people associated with these power centres and officials of philanthropic foundations. Websites of the respective foundations are also a source of information, which is used in this section.

Indian philanthropy is associated with religion and caste rather than 'secular philanthropy', seen globally. This association is not exclusive to Indian philanthropy; however, many significant features are visible in this phenomenon. When global philanthropic foundations use grants to influence recipient bodies, foundations in India use their religious and caste identities to expand the 'business market'. However, both claim to do charity for the welfare of vulnerable people. This thesis has discussed in previous sections that the foundations in Kerala and their educational institutions serve the middle and upper class of the society rather than the needy and create a substantial economic burden over the users.

Three foundations belonging to three social identities from three different locations were selected for the study. Operationally, these are denoted as a '*Trust'*, a '*Foundation'* and a '*Society'* from Kerala's south, central and north regions, respectively. However, these foundations relocated their medical institutes from the headquarters' locations. The Society's inception was in Kozhikode district, but the institute is located in Malappuram, the headquarters of the *Trust* was in Kollam district and the institute is in Ernakulam. The relocation indicates two junctures in history; one is

"The horrors of 1921 (Malabar rebellion and Muslim persecution) *and partition in 1947 created impediment in the development of Muslims and other backward communities. They desperately needed an agent who could drive them into the light of education. Hence the inception of the 'Society' is a timely venture for the transformation of Muslims in the educational field. Then the 'Society' was established in 1964 and the last five decades have been witnessing the transformation led by us."*

(Dr. Soc, Exe. member)

Philanthropic foundations based on caste and religion emerged upon specific objectives based on the need of that historical period and they performed well. However, the socio-political transformation of philanthropy occurred after 1990 in Kerala. Rather than imparting elementary education and providing primary healthcare to people at the fringes of development, foundations concentrated on building advanced techno-centric tertiary care hospitals and "sophisticated" medical colleges at urban centres.

"The founder mother had a dream of building a hospital where poor receive advanced medical care free of cost that led to creating a referral and teaching hospital in Kochi in 1998. We selected this location after considering the accessibility; the hospital is near to airport and railway station and public transport comes to the hospital's doorstep so people from all sections can reach here easily. The hospital has provided free services to millions of users so far and has been providing treatment at an affordable price and one-third of them are either free or subsidised."

(Dr. Nair, Director)

On the other hand, their claim of charity service in terms of free healthcare is not identical to the data collected from these hospitals. It shows that 76 per cent of the users in philanthropic hospitals did not receive a reduction in the total bill amount and the remaining 24 per cent received below 20 per cent reduction from the amount. When compared to caste, economic and educational status, 60 per cent of the users belong to the middle-upper sections, and they come from urban locations.

"They (foundations) *performed commendable charity works moreover these institutes* (medical colleges) *open doors for many students like me who dream medical graduation but could not get admission in general quota. If these institutes had not existed, I would not have been here. I know many cases similar to mine. Yes, regarding fees, it is very costly may be higher than some other institutes, but the facilities and exposure are also different."*

(Student-1A)

It is not surprising that the middle and upper-class of society benefit more from neo-liberal economic policies. Philanthro-capitalist foundations have rapidly grown after the introduction of the new economic policies in the 1990s. They are the devoted groups of these institutions who are forced to protect the authority system of philanthropic institutions either for specific community interest or due to helplessness. As a result, a symbiotic relationship between foundations and users has been developed. The authority system has been generated in different ways, which will be discussed in the coming part.

Rules of Authority in Institutions

Authority is the likelihood that specific commands will be obeyed by a given group of individuals based on the ground of habituation or specific rational grounds. Philanthropic foundations or the leaders of these foundations have gained legitimation of devotees, which was created through three ways, as Weber explains. The legitimacy of charismatic authority relies on hero-worship and devotion because a specific quality is believed to be extraordinary and sacred. Charisma is referred to as vital quality of individuals.

Traditional authority is established beliefs in the religious sanctity or traditions and the legitimation to exercise that authority. In contrast, rational authority is the legitimation of enacted rules and those who issue commands based on such rules. It is based on the legally established impersonal order and the person who occupies the office exercises the authority. Along with the intersection of traditional, charismatic and rational authorities in each foundation, they embody specific authorities for institutes' functioning and development. When the *Trust* is interwoven with charismatic authority, the *Foundation* and *Society* connect with traditional and rationale authorities.

"Through extraordinary love and altruism, she has endeared to many people. She tenderly hugs everyone who comes to her. It is her innate nature holding them close to her heart through a loving embrace. Whether they are rich or poor or sick, everyone experiences her unconditional love. She has hugged more than 39 million people in the past forty years. Her religion is love; Guru does not ask anyone to believe in God or change their faith. The most significant element in establishing this (institute) *is her compassion. It was founded on the principles with an emphasis on compassionate service to people, charity and excellence."*

(Swami, a group leader)

An individual influences millions of people belonging to different social categories using charismatic authority, which helps develop a massive base of devotees worldwide who are considered a 'charismatic community'. The devotee maintains an emotional relationship with the leader, which is beyond the general norms, and hence it is irrational in that sense. The devotees believe that Guru's extraordinary quality is love, which can bring changes within individuals. Whether it is actual, presumed, or alleged does not make sense, but the governed submit to the leader by virtue of personal trust in that quality. At the same time, she has to institutionalise her 'divine power' to sustain the position she holds within the minds of individuals. Hence, she undergoes the routinisation of charisma through rigorous ascetic practices. Once the institutionalisation of charisma takes place, they need social and political recognition.

"She began a tour during which more than 200 volunteers accompanied; our plan was riding four buses in eleven cities. She sat on stage for 15 hours at a stretch cross-legged at each place and hugged thousands of her devotees! It repeats every day without a break for food, refreshment or other needs."

(Maya, a disciple)

Individual charisma results in the development of an institution, or sometimes an institution becomes the object of charisma. The hospitals run by these philanthropic foundations are centres of charisma and users submit to them from individual weakness or helplessness as no alternative is available. The charisma of a hospital or a doctor influences 44 per cent of users in selecting philanthropic hospitals for care. The advertisement of hospitals

focusing either on a renowned doctor or highly advanced technology creates an aura among the healthcare seekers. Their claims are like *"it was introduced in Kerala by us, which is very useful for early cancer detection"* and *"robotic surgical assistance is a recent addition"*. The charisma of a doctor is also marketed as *"we have heard about the doctor; skilled and specialist for kidney stone treatment."* Hospitals empanelled with a wide range of third party administered (TPA) private insurances are also an extra quality, which attracts the users.

From the users' perspective, the charisma of the *Saint* is 'sacred' and 'divine' and they possess magical 'healing power'. An administrative officer in Kerala legitimates, 'the Guru organised a cleaning task at a huge pilgrim centre, where the government had failed to execute it in Kerala. Even though the Guru was on a foreign tour, it happened within days because *"the Guru possessed divine authority"*. Similarly, every third user legitimises the 'sanctity' of gurus and 41 per cent believe that they can cure certain diseases through a 'healing touch'. Devotees buy medicinal flowers from shops run by the *Trust,* believing it can cure the common cold, different aches and even cancers. *"If Guru touches it, the Guru's energy transfuses into it."* People rush to the *Saint* seeking discharge of mental stress or bad fortunes. As one devotee said, *"People take house-loans, education-loans and car-loans at high-interest rates. I take loans to meet the Guru for my spiritual growth and am financially indebted to banks."*

Weber says that these needs integrate more with psychological and emotional elements than rational and intellectual factors. In addition, 'need fulfilment' varies according to the social status and position of individuals. At this point, a charismatic leader plays a significant role in individuals' quest for material benefit, which may be in terms of health, economy, and status.

Weber says that charismatic authority is primitive in its ideal form, which is the antithesis to rational authority because it is oriented to a set of established rules. Bureaucracy is a pivotal part of the rational authority in which authority is decided on the merit and skill of individuals. The person of authority is elevated to the office based on abstract legal norms. However, caste and religious-based philanthro-capitalist foundations equally consider the degree of devotion and intimacy and the skill and merit of individuals. Sometimes it overrules the latter, which indicates the synthesis of charismatic and rational authority. In a bureaucracy, the vice-chancellor (VC) and registrar are organs of the administration to apply rules. They usually are elected based on their academic merit. In the caste of *Trust,* charismatic leaders are superior to rational authority, which contradicts Weber's ideal type. Here, the chancellor's

university office run by the *Trust* is occupied by the charismatic *Saint* for a lifetime. The president and pro-VC of the university are obedient, trusted devotees of the Guru.

> *"Guru is the founder and inspiration of the Trust. Hence, she holds the office of the university chancellor. President, executive member and Pro-VC are disciples of the Guru. However, they do not intervene in the affairs of the university unnecessarily. It is not a matter of their academic excellence but the vision and energy considered* (assuming their office). *It is an undisputed fact that she is superior to all due to her charisma and influence."*
>
> (Prof. Sag)

The *Saint* is legitimised through employing charismatic authority and their foundations are equally rational and charismatic, at least in this case without any conflict as Weber observed. At the same time, the power of this leadership is not explicitly visible, but it is exercised through unnoticed ways using norms and social conventions, which is called hegemony. Religious and caste-based foundations use ideological and traditional tools to secure their hegemonic power, considered more stable and wide-reaching. The degree of religiosity of users and the social structure in Kerala contributes to expanding the Saint's realm. While analysing the religiosity of users, even 'selectively religiose' people are predisposed to the gurus' authority and legitimate charisma.

On the other hand, *Society* is a 'rational bureaucratic organisation of administration' established on the legality of rules. Scholars of Weberian school say that he did not deliver a value judgement while using the term 'rational' and did not imply that one is superior to the other. The *Society* has a written bylaw, which was legally enacted after mutual agreement. The office of authority is decided based on a set of accepted rules upon which the organisation functions.

> *"We have an approved bylaw, which proves the democratic character of the Society. It states that any individual with an age of 21 years and wish to associate with us can be a lifetime member* (of the Society) *by paying the application fee and monthly subscription fee. The bylaw decrees that all members have equal rights and privilege and it demarcates the duties, roles and responsibilities of the individuals who are assumed to offices. It also explains*

the organisational structure, tenure and election procedure. The Society has a state executive committee for three years, which the Electoral Committee members elect and it has a general body consisting of all members of the Society."

(JP Sec, MES)

The given legal rules are legitimised on the ground of value-rational and all the members of the *Society* carry out 'social action' based on these rules. The person in authority who is considered 'superior' or 'official' should obey the rule as far as a member of the *Society* and dispose of commands based on the mutually agreed rules. At the same time, other members of the *Society* obey impersonal rules and not that particular person in authority. However, 'centralisation of power' in a rational-legal system can be emerged, which happened with the *Society*. Philanthro-capitalist foundations have been using rational-legal authority to influence the people associated with them.

"We have given notice to the executive committee to discuss it in the upcoming general body (in 2018)*. It points out certain serious allegations against the leadership, including a constitutional amendment that aim the lifetime president-ship instead of three-year tenure, which was not even informed to the registrar. The new amendment will destabilise the democratic character of the Society. The president's nomination was an act of favouritism to legitimise his lifetime authority. They started a business venture despite the illegality that the Society shall not have venture. One hundred crores medical college project turned into a family joint venture. These are against legitimised bylaw; hence amendment is proposed."*

(Dr. Anon, former Exe. Member)

A person in authority can be the supreme authority using the same system of legitimation by making slight amendments to the agreed rules. The new amendments undergo the legitimation of the members in the same way as it was gained earlier and thus arise the dispute within the administrative structure. Those who centralise power need psychological justification for their position and privilege. Theoretically, the legitimation process is not wrong and the amendment can be justified, but a *Society claiming* charity purpose must be evaluated publicly. While responding to the allegations, persons in the office can defend their

actions by using the same bylaws; *"the opponents failed to fight with the Society's bylaw and tradition thus unleashing the delegitimising campaign."* Tradition and charisma may contribute to the justification and thereby gain legitimation.

In the case of traditional authority, the legitimation of the *Foundation* is claimed from an external legal order where a religious body manages the system of rules. *"In 2003, he was sanctified and installed as the Metropolitan Bishop. He remains grateful for the godly heritage of his parents."* In contrast to charismatic authority, the traditional authority of a *Bishop* was sanctified by an external agent, which has an ancient lineage; hence the 'position' cannot be terminated on rational grounds. The person is elevated to an authority, named *"Moran-Mor Athanasius",* through a system of consecration process in Christianity. The consistency of believers towards sanctified ancient traditional rules organise obedience to their *Bishop.*

The charismatic authority claims obedience by virtue of personal qualities, which are considered supernatural and sacred. The charismatic *Saint* never speaks about a particular religion even if it is evident; she says, "love is my religion, *and I do not ask anyone to believe in God or change their faith."* While in the rational-legal authority of *Society*, the legitimised bylaw is bound with the secular idea of modernity. However, in *Foundation,* authority is bound with traditional religious values; hence, religion appears before the believers. Charismatic authority is attached to the *Saint,* which develops a cult, but in traditional authority, the 'office' is attached to the religion; thus, the charismatic authority will be replaced by the traditional authority after the period of *Saint*.

> *"The medical college hospital is a healing arm and one of the major healthcare projects of the Church. It also involves rehabilitation projects, charity activities and educational projects. Dr Metropolitan Bishop is the chief patron of the hospital. The hospital aims at providing cost-effective holistic care for ordinary people without compromising quality in the spirit of Christ. The contribution is primarily from the followers of Bishop and we use funds wisely and effectively in Christ's name."*
>
> (Anonym, Project MCH)

Symbolic Routinisation of Authority

This section analyses the association between symbols and routinisation of authority. By routinisation, Weber means that social change occurs through transferring authority from an individual to the institutionalised entity. Weber emphasises that routinisation is the transformation of original charismatic energy into more permanent forms. Saints and leaders of foundations based on religion and caste use symbols to subtly exercise power and authority to control others. The charismatic *Saint* influence every movement of the followers. Gurus' actions, gaze, clothing, and even the building structure contribute to routinisation, also called materialisation of authority. Hence, we call this phenomenon 'symbolic routinisation of authority'.

Prayers and hymns affect the spiritual life of believers, which is believed to influence the health of individuals and they say that *"it* (prayer) *is a call from the god and gives inner peace. If we attend it, the Bishop prays for us and gets cured."* However, in another aspect, these symbols are used for the routinisation of authority, which seek compliance with the authority.

> *"Metropolitan touches millions through radio programme 'Athmeeya Yathra'* (spiritual journey) *and TV shows. It is played in the prayer hall of the hospital every morning and evening; nobody is forced to attend these sessions. People who voluntarily attend this testify the experience of spiritual healing, which develops hope in their life."*
>
> (Project MCH)

> *"The picture of Saint is placed at every nook of the building, which creates a sense of belongingness, peace and feeling that she is with us."*
>
> (HC Seeker)

> *"You cannot escape from Saint's gaze while you are in* (this institution)*; it is a control mechanism like in an army-ruled state where everybody is under a camera surveillance of the 'chief'."* (giggling)
>
> (HC Seeker)

Persons in power employ different methods to routinise the authority and gradually elevate them to higher positions. The routinisation creates a larger base of devotees for spiritual

leaders who exercise power. The perpetuation of personal devotion to the charismatic authority cannot be guaranteed after the disappearance of charisma or the leader's death. There comes the problem of succession and continuation of the charismatic community (devotees), which demand institutionalisation in placing *Saint's* portraits and playing *Bishop's* prayers. The close followers of the leader began imitating by wearing the same garments as part of the routinisation of authority. One follower of the *Saint* and a teacher of the institute says,

> *"Guru leads simple ascetic life; loves dressing simply. She wears a white or saffron-coloured saree and we follow the same. Above all, she is a great model of unconditional love. It is how we express our respect and obedience to her greatness."*
>
> (Madam, Gari)

Big-charities for the Legitimation of Philanthro-capitalism

Middle and upper-middle-class people of the society is the strong devotee-base of spiritual leaders cum 'philanthropists'. Similarly, hospitals and educational institutions run by these philanthro-capitalist foundations cater to the needs of the dominant-caste and upper-class people rather than the poor. Despite this reality, their various literature sources highlight the foundations' big-charity activities because the very existence of each foundation is, in terms of the legal entity, considered a charity organisation.

> *"During the initial years, the Society focused on promoting education and started scholarship assistance to the deserving students. The Society initiated building educational institutions at very remote and underdeveloped villages to provide access to unfortunate poor and deprived segments* (of society)*. This great venture provides education to 80,000 students through 150 institutions across Kerala in which eight institutes are solely for women."*
>
> (Lea, Society)

However, their capitalist motive is legitimised in the guise of 'big charities'. These foundations claim charity worth huge sums of money and all other activities are legitimised owing to this. All other business motives and profit orientation can be covered up under the guise of charity. Hence, they need legal and psychological legitimation of 'charity among the most deprived sections of society.'

"Philanthropic organisations carry out many welfare activities for humanity like healthcare service, feeding the hungry and giving shelter to the poor. It needs money, so organisations take it from the fortunate people. Wealthy do not want education and healthcare services at free of cost."

(Doctor, employee)

It would seem that a significant share of their contributions is disbursed chiefly for the welfare activities, but the evidence stands contrary to this claim. The *Society* had initiated commendable activities in the education sector but gradually moved to capital augmentation. It leads to the exclusion of the poor from medical education. It has "acquired assets worth 6,000 crores of rupees", but students have to pay a million rupees as a capitation fee to secure a medical seat in the institution.

"I paid 70 lakhs rupees (capitation fee) *to ensure the seat in the management quota due to my lower rank* (in the medical entrance exam) *and some paid 40 and it varies depending on your rank. The annual fee is also high, which is difficult to bear even for a student belonging to a middle-class family. The entire course fee is projected to 70-80 lakhs rupees, including all expenses; thus, I owed a bank loan of 18.6 lakhs for which the monthly repayment is 36,000 rupees, which will be started after the course."*

(Sal, Medical Student)

A medical student completes the course with substantial financial liabilities to banks; 80 per cent of the medical graduates are indebted to banks. Fifty per cent of the medical students are not getting an educational scholarship. The institutions provide scholarships to selected students only; within them, middle-income families benefit more. It indicates that the foundations carry out 'philanthropy' outside their educational and healthcare institutions.

"The Trust has achieved many great things during the short period. The 2004-Tsunami rehabilitation was a big project of 100 crores rupees, building houses for the victims. Then it provided 100,000 scholarships for children from impoverished communities, free vocational training for 500 students and a secondary school for 3,500 students. The Trust has treated 4.1 million users for free through our hospital, worth $60 million. It extends monthly pensions for 50,000 widows and the disabled. It has undertaken 100,000 cleanup drives that

impact India's public health goals. Moreover, the Trust runs several feeding programmes for the poor, mostly abroad and in India also.

(*Trust* Web)

The *Trust* combats some of the social problems extravagantly without addressing the structural attributes of the problems. The unfortunate will be delivered goods and services lifelong due to the kindness of a charismatic and religious leader or as long as a foundation has enough money to spend. It hardly makes any 'change' in society, as philanthro-capitalists argue. At the same time, their capital is augmented through 'philanthropy'.

"Fishing families in Paraya village (where the *Trust* HQ is situated) *live in tiny sheds and some of them relocated to other places due to fall of fishing-work and sea erosion. The entire village falls under an ecologically sensitive area; hence the CRZ* (Coastal Regulation Zone) *rule prohibits fisher-folks from permanent construction. However, the Trust violates all regulations by using power and authority and constructed more than 60 buildings, including a 14-storey building, which will be disastrous to the environment. They are indebted to the Panchayat for crores of rupees tax; if it had been paid, the living standard of the people in the Pacnhcayat could have changed radically."*

(Panchayat Secretary, Huffpost)

The *Trust* could not improve the living standard of the people in the vicinity of its headquarters. Above all, devastating environmental violations of an organisation point out that the claim of 'big charity is insincere and for the sake of legitimation only. It is found on the FCRA website that the *Trust* spent only 0.69 per cent of the total funds for relief, rehabilitation and charity activities; 57.94 per cent were spent for maintenance and construction of the hospitals and educational institutions and the remaining 41.37 per cent were spent on other purposes. Hence, the major activity is maintaining the field of business in the pretext of big charity.

Most of the unquantifiable charity activities do not reach the deserving hands. Evangelical Council for Financial Accountability (ECFA) issued a notice against the *Foundation,* stating that *"Approximately $184 million cash balance in bank accounts, which received a year back and found a delay in sending funds to the field. It solicits enormous funds*

for a narrower purpose..." The notice concluded after the interrogation that *"funds are not reached to the right hands."*

The Implication of Religion and Caste

Different types of philanthro-capitalist foundations function in Kerala. They opened services to people from all religious and caste groups by seeking profit. It can be categorised into rational-legal, traditional and charismatic foundations based on authority. In addition, the profit motive in the guise of religion and philanthropy is a common factor between these foundations. However, the implication of religious identity varies in each organisation.

For instance, *"sharing the gospel is one of the activities of the Organisation"* and *"medical college is the healing arm of church",* which shows that the *Foundation* asserts Christian association. Hence, the legitimation process takes place in the realm of tradition by virtue of religion. In the case of *Society,* Islam operates subtly. Even if visible, they emphasize modern rules of democracy and bureaucracy by virtue of a bylaw rather than religious values. Finally, the *Trust* is a cult group, which has grown by virtue of a charismatic leader within the realm of Hindu religion. When the charismatic leader was asked about religion, the reply was, *"my religion is love",* and did not say about a particular religion. However, the source of entire actions is indebted to Hinduism. Moreover, these foundations owe to the capitalist idea rather than the philosophy of any religion. Philanthropy is employed for bourgeoning their asset.

> *"If this were a traditional ashram with huts and rice gruel, there would not be these many people, or they would come for a day and then leave without staying. Saint feels it would be a disaster if people did not come here for their vacation because they could not get a pizza, so okay, we have pizza here, a cappuccino and a swimming pool. Some may feel that it is a bit opulent for an Ashram."*
>
> (Dante, Volunteer of *Trust;* NYTimes)

Neoliberalism and globalisation intensify the growth of old-fashioned capitalism with a new appearance and philanthro-capitalism are one among them. As India stepped into the new economic order, it affected every sphere of human life. It unleashed unending material needs of middle, upper-class and dominant caste people. Gurus come into the minds of such dominant sections, who have spiritual and material aspirations but are least attracted to traditional religious practices and seek new-age spiritualism. The role of spiritual gurus gets

significant in this atmosphere. The speeches of saints seem to be philosophical and scientific to the followers, which satisfy the needs of aspirants in a more personal way.

The Foreign Contribution Regulation Act (FCRA) website provides the list of donors of philanthro-capitalist gurus. It includes migrated middle-class and dominant caste NRIs who donate thousands of rupees that constitute millions of dollars every year. Similarly, among the users, 82 per cent of government employees, 80 per cent of private employees and 92 per cent of businessmen believe in the 'divine power' of spiritual gurus. However, labourers constitute only 14 per cent in the category of 'divine power' believers. In the case of users' education, 46 per cent of higher-educated believe in the charisma of gurus. It is also notable that 95 per cent of the respondents from the forward castes are predisposed to the power of spiritual leaders. In addition, if we peruse the age of the followers of these gurus, middle and old-aged are more attracted to them. In this way, the income, educational attainment, assets, political belief, taste and lifestyle of the followers indicate that the upwardly mobile wealthy middle-class are the staunch supporters of spiritual-philanthro-capitalism.

> *"I left government hospital due to inefficiency and lack of quality in the services. Private hospitals do best in this; if a government hospital is handed over to the private agency as an experiment, they will teach services. The cost of care will be higher here, but you get cured. I believe this money will be spent for charity purposes, so it is the nicest way of doing business.*
>
> (A healthcare seeker)

During the last three decades, spiritual-philanthro-capitalism has flourished rapidly in India and Kerala under these leaders. For instance, Sudhamani was 'formally' given the name *'Mother Devi'* in 1981 when she was 28 years old and the Mission was formally registered in the same year. Similarly, 'Yohan' founded 'Gospel' in 1980 in his 30s. Spiritual leaders, godmen, saints and gurus emerged as delivery agents of material needs of affluent sections.

> *"Human suffering is due to karma* (the outcome of one's performance in the past). *If it is one's Karma to suffer in this life, isn't it our dharma* (duty) *to help alleviate suffering?"*
>
> (The *Saint*)

Human suffering and its alleviation are the 'dogma' of gurus. They accumulated massive capital out of human suffering and material need of fortunate, which is a product of neoliberalism. Weber observes that religion and suffering are connected in a significant way where the former makes the apparent world seem ordered and meaningful. As a result, religious people cope with suffering and thus imply uncertainty in life. These spiritual gurus utilise it by explaining that unfortunate and fortunate are created not because of unequal distribution of resources but because of '*Karma'* or predisposed.

> *"There is no unemployment among uneducated in India; plenty of employment is available, but nobody is ready to work. If farmers are committing suicide, it is because of their lack of education in agriculture."*
>
> (Sri Sir, Tehelka, 2009)

In other words, they justify that the wealthy deserves to be wealthy and thus, the poor themselves are responsible for their condition. People from upwardly mobile middle-class and dominant caste sections need this type of justification for their fortunate life. Hence, they rush to gurus and contribute a portion of their fortunes to alleviate the suffering of the unfortunate. Hence, capitalism succeeds and inequality persists.

Conclusion

Capitalism takes new shapes according to Spatio-temporal and social factors. Philanthro-capitalism is a new form of old capitalist idea pertinent to the 'accumulation of private wealth' in the guise of charity. In India, it intersects with religion and caste. The power and authority of philanthro-capitalist gurus and foundations are more profound and wide-reaching due to the intersection of religion, caste and wealth. Indian philanthro-capitalism is peculiar in this sense and it is an outcome of the political atmosphere rather than the transformation in religious activities. In healthcare and medical education, governments' withdrawal from investing in public goods, liberalisation, and globalisation policies shot up the religion and caste-based philanthro-capitalism. Philanthro-capitalist foundations divert charity contributions to these sectors to run hospitals and medical colleges. Their operation is based on utilising charismatic, traditional and rational authorities in a highly religious-oriented society.

Moreover, widespread devotees of each foundation and guru, especially the middle-class section, significantly contribute to materialising legitimacy. They exercise types of

authority for the legitimation of profit-oriented activities. Weberian theories are helpful to interpret this phenomenon though the features of Indian philanthro-capitalism cannot be explained fully. Every foundation is a synthesis of different authorities, which help them influence various population segments. Weber conceptualises social change in terms of the 'dialectic interaction' of charismatic and traditional authorities. For him, rational-legal authority is an outcome of social change and modern concepts, which will not coexist with former authorities. However, Indian philanthro-capitalism is a synthesis of authorities.

Inferences and Discussion

Philanthropy and capitalism imply different philosophies, though a new thought from the same old capitalist ideology was born as philanthro-capitalism for-profit augmentation in the guise of charity. From the prehistoric period, charity originated from an altruistic character of humankind, which intended to alleviate individuals' torment. Before the advent of the nation-state, religious centres were important actors in this toil. They collected individual contributions and provided shelter and food to the destitute. It gradually became an organised act when external agents and industrialists started focusing on the welfare of specific groups like labourers, women and migrants (Sajid, 2015). However, it was not considered as the right of industrialists to reduce the inequality between social groups. When modern nation-states emerged, education, health and wellbeing and welfare of citizens became the prerogatives of a welfare State.

Foundations' Growth, Disparity and Disinvestment

In India, the Constitution mandates that health and education are two leading responsibilities of the State. The provisioning of education and healthcare services are placed in the concurrent list; hence it is the responsibility of each state of the country to ensure it for the citizens. For the last sixty years, the state of Kerala has achieved substantial growth in healthcare infrastructure, accessibility and utilisation (Economic Review [ER], 2017; Human Development Report [HDR], 2005; Kutty, 2000). As a result, Kerala is ranked top in social development indicators, among other states in the country. Nonetheless, inequality based on social identities and regions persists over the period (ER, 2017; Sajid, 2019; Jacob, 2014; Devika, 2010; Chakraborty, 2009). Caste practices; untouchability, pollution and concomitant social exclusion, on the one hand, administrative laxity due to political insurgency during the British period, on the other hand, are major historical reasons for the prevailing inequality in the state (Kabir & Krisnan, 1991). Volunteers of charity organisations had come to rescue the expelled and provided basic amenities even though it did not fill the gap (*ibid*.). Charity organisations gradually increased and underwent significant transformation influenced by regional and global factors (Osella & Osella, 2009; Nundy, 2014).

Philanthropic foundations that emerged at certain historical junctures based on social identities served the welfare of people who faced discrimination during the initial stage. However, these foundations invested in healthcare and medical education, which were 'largely

privatised social sectors' (Dilip, 2008; Levesque et al., 2006) in the state seeking profit. The profit-oriented transformation began in the 1980s and strengthened in the 90s, after opening neoliberal economic policies in India (Sajid, 2015). During the same period, Kerala witnessed mushrooming of 'philanthropic' centres under the leadership of spiritual gurus interested in healthcare and medical education and their 'patented' religious practices (Krishnakumar, 2013; Zacharia, 2012). They grew not only as wealth centres but also as the legitimised authorities who can influence various segments of the society at large. It can be interpreted through the lens of Weberian theories on power and types of authorities, which he explained in Economy and Society (1921). *Philanthro-capitalism in healthcare and medical education* is a study on the capital augmentation of philanthropic foundations in the guise of charity in Kerala. It analyses the exercise of power and authority of foundations and leaders in the virtue of religion and caste identities.

Kerala had shown signs of economic crisis from the 80s prelude to neoliberal policies implemented by the Indian government in the 90s. As a result, the state government started disinvesting from social sectors, which upshot the stagnation of healthcare infrastructure development (Madore et al., 2016; Kutty, 2000). It also widened the regional disparity that existed between the northern and southern districts of Kerala, where northern districts witnessed a deficit of public institutions and human resources; like hospitals, schools and PDS shops, medical officers, ASHA workers, physicians and healthcare technicians (Director General Health Services [DGHS], 2014; HDR, 2005). It produced two significant changes; one is booming of private and philanthropic sectors in this gap (Dilip, 2008) and another is the burgeoning of 'philanthropic' spiritual leaders (Krishnakumar, 2013) who heal the spiritual and material distresses of the people of the middle-class and dominant castes (Varma, 2012). The dominant-caste distress, also middle-class, is a concomitant consequence of liberalisation and globalisation of the Indian economy (Nanda, 2009), which found solace nowhere other than at a modern guru. Many successful gulf-migrant Keralites invested time and money in innumerable social projects during the same period, especially in the backward northern region (Osella & Osella, 2009).

Philanthropy, Capitalism and Legitimation

Historically, Charity has been used to form authority and legitimation, social status and patronage (Palsetia, 2005) that eventually leads to economic and political advantages (Osella & Osella, 2009). Modern gurus and their centres gained authority and legitimation through 'big

charity and accumulated assets worth million dollars selling spirituality, education and healthcare services. Education is an 'over-determined development marker' among the Indian middle class (Jeffrey et al., 2008) and hence, earlier philanthropists and organisations focused on promoting education in Kerala. They gradually shifted focus towards healthcare and medical education in post-1991 (GOI, 2014). As a result, hospitals and medical college institutions managed by religion and caste-based philanthropic foundations have increased in the state (Sajid, 2019).

Another reason for the shift is that the management incurs huge income from medical education (Prasad et al., 2016); through annual fees and capitation money. It reminds us that the medical graduates of such institutes will always be from the upper ladder of society; only those with social and economic capital can afford the heavy fees of medical education. Social identities of the healthcare providers influence the access and health-seeking behaviour of people, which aggravate inequality in access (Acharya, 2018). In addition, these institutes produce a financial burden over the medical graduates due to the higher fees; thus, they seek to profit from the users to repay their education loans, which again raises the cost of curative healthcare. In practice, philanthropic hospitals are more like private hospitals though charity has been employed for the legitimation of their power, authority and profit augmentation. It demands a policy intervention on education fees in medical institutes based on social and regional vulnerabilities apart from the 'quota fees'.

The shift took place not only in terms of services but also in the geographical location of foundations. The place of inception of each foundation was 'conveniently' migrated to urban and town centres based on the market interest after the 90s. They claim that the 'migration' makes sure that the services are "easily accessible" by "care seekers". The migration is either to the "hub of hospitals" or to urban locations where wealthy people are surrounded, the care seekers of such hospitals. Hence, economically and socially vulnerable sections like tribals cannot access it.

Moreover, 'access' is a particular notion that is not meant for mere physical reach. However, it is also a combined result of 'awareness, knowledge, information and the favourable environment to use these services (*ibid.*). In addition, urban-oriented relocation raises the cost of curative care more than the cost in hospitals located in panchayat or villages, and it incurs higher catastrophic health spending (Centre for Public Policy Research [CPPR], 2017). Accessibility and affordability are at stake for the poor and the spending intensifies the

burden to ‘multi-dimensionally poor’ and vulnerable coming from poorer regions (Acharya, 2018). Hence, the relocation results in the exclusion of people accessing healthcare based on their social, economic and geographical vulnerabilities. For instance, the government can insist that free beds and free wards are opened within the philanthropic facility for the deserving and a recurrent appraisal on the utilisation of such wards can be ensured. It warrants a systematic assessment of inequity across various social groups in accessing healthcare services provided by philanthropic hospitals. Consequently, the government can develop a policy that ensures equity in healthcare access in these centres.

Power, Authority and Social Class – Weber’s Paradigm

Devotees or members are the income source or donors of these power centres who belong to a particular class that demands further attention. The routinisation of authority and legitimation process occurs by virtue of this large devotee base spanning various countries. While considering their social class, property ownership or economic power is usually given more importance and an individual's social and regional identities are partly ignored. Philanthro-capitalist centres speak about ‘poor’ in economic terms and ignore other social disadvantages of individuals. Hence, they fail to develop a systematic method to identify the ‘deserved’ people. Apart from the economic condition, a class is determined by the social location of individuals, status groups in which individuals belong and the ability to call for a social action, which is called power (Weber, 1921). Furthermore, the status group involves lifestyle, consumption pattern, conventions and economic status monopoly (Kalberg, 2005; Weber, 1921); that is, it can be considered a caste group. The power is manifested so that they can legitimate a guru from an oppressed caste and create wider acceptance beyond the notion of purity and pollution while keeping the living condition of that particular caste group underdeveloped.

Even if the devotees or members of philanthropic foundations are a mixture of all classes, a large section of them has the features mentioned above. They benefited from economic liberalisation and globalisation, which opened a sea of opportunities like IT and Business Office Processing (BOP) for upward mobility (Nanda, 2009). On the other hand, rising inequality in society may irritate them regarding the ‘middle-class’ burden’ of alleviating human suffering. Eventually, their search for solace will end at the altars of ‘charismatic’ centres. Their much-hyped ‘big charity activities psychologically satisfy the middle-class and provide a philosophical justification for persisting social inequality. Since both are products of

globalisation and economic liberalisation, a symbiotic relationship develops between them, which is called reciprocity of parasites. It indicates that in certain social situations, charismatic leaders are created through a course of action by exploiting the emotional elements of devotees. This course of action which McCulloch (2014) called "charismatic transformation", is the great 'desperate social schism'. The charismatic transformation of individuals is possible only when a 'status group' like caste or religious group that occupy power and authority assists and is possible only when a desperate social situation like anarchism or grave inequality exists. The mythical creation that bridges tradition and modernity is an essential factor in the transformation. Eric Hobsbawm named the bridging as 'historic continuity' (cited in Nanda, 2009).

Currently, the policy environment is favourable for foundations to expand their capital and power in the guise of philanthropy. The demarcation between philanthropic and private sectors needs to be redefined based on the service delivery and outcome, service charges, beneficiaries and spending. The policy will allow a bottom-up appraisal from the beneficiary to the income sources of foundations apart from submitting the annual financial statement. It is equally important to develop a mechanism standardising cost, fees and service charges across these institutions.

Conclusion

Globalisation and liberalisation brought drastic changes in social actions that occur in various social domains. Philanthro-capitalism is a product of a new economic (dis)order that aggravates inequality based on individuals and groups' social, regional and economic conditions. New power centres of philanthro-capitalism provide service to 'some' that need to be socialised for all. There is sufficient research available on social exclusion, discrimination, out of pocket expenditure and healthcare utilisation. Most of them are conducted in public or private settings, but such studies should also be conducted in philanthropic institutions. This study may contribute to a larger academic activity identifying the 'iceberg' in the deep sea. As a third sector, research on philanthropic institutions has much scope and it is extremely significant in this globalised epoch.

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Appendix-I

Interview Guide for officials from philanthropic institutions

Inception

1. Is it a trust or society?
2. What was the motive to start a philanthropic institution at that time?
3. Where and when was the trust registered?
4. Why did you prefer this location for the trust/society?
5. Why did you choose this location for the hospital (If the trust and hospital are located in different regions)
6. Would you elaborate on the name of the trust? How was it selected?
7. What are changes happen to the trust in Kerala?
8. What kind of international linkages does the trust have in terms of technology exchange programmes?

Trajectory of development

1. Where are the other centres located under the trust and when was it started?
2. Why did you start a philanthropic hospital instead of a private hospital?
3. Why did you open medical college or super speciality hospitals rather than primary health centres?
4. What were the major difficulties you faced while starting the hospital?
5. How was it managed?
6. What is the total patient load here?
7. How many staff is working here now?
8. Give a brief on the infrastructure of the hospital?
9. What are the specialities of the hospital that other hospitals do not have?
10. What is the contribution of the hospital in the development of vulnerable sections?
11. Do you ever help the government in policymaking? If yes, please explain?
12. What other activities the trust is doing to help the government (implementation)?

Survival of the Charity

1. Is the hospital providing free health care?
2. What is the proportion of users getting free health care in a month?
3. How does the administration manage to survive the charity in a time of expensive care?
4. Do you reduce the cost of health care for users?
5. How many per cent of users benefit from the reduction?
6. What are the criteria to select the poor for free care and reduce the cost?
7. What do you say if free health care is given to all?

8. What are the activities you do to meet the health needs of vulnerable people?
9. How do you ensure people from vulnerable sections can access this hospital?
10. Are there any free beds in the hospital reserved for the poor, if yes per cent?
11. Do the eligible users avail this facility of free beds? If yes, how many per cent?
12. What are the measures you have taken to ensure this?
13. Is it mandatory by law to keep free beds reserved for the poor?
14. Do you donate to the state govt? If yes, for what?
15. Do you donate to any organisations?
16. What is their nature? Political☐ NGO☐ Religious centres☐ Others
17. What is the proportion of foreign users in the institution?
18. What services do you provide to foreigners?
19. What are the key features of this hospital to attract foreigners?
20. Do you accept government health insurance? If yes, what are they?
21. What are the marketing strategies of the hospitals?

Funding

1. Are you exempt from the tax payment?
2. Did you get government aid in any form like land or grant?
3. Did the institution face any disfavour from the state at any stage?
4. Do you have FCRA?
5. Do you get an exemption under 80G?
6. Are you receiving foreign funds for the hospital?
7. What is the average expenditure of the institution per month?
8. What are the income sources of the institution?
9. What is the expenditure incurred for education and healthcare (in per cent)?
10. Do you have plans to start new hospitals in Kerala?

Medical Education

1. What kind of medical education centres do you have?
2. How many seats in each centre have?
3. What is the annual fee for medical education?
4. On what basis the admission has been taken place in management seats?
5. How many seats have been reserved for NRIs?
6. Do you consider students from disadvantaged social groups?
7. If yes, what is their per cent?
8. What social disadvantages are being considered at admission?
9. How do you consider them?
10. What is their annual fee?
11. Do you keep reservation criteria for admission to the institution?

Management and Governance

1. What is the organisational structure of the institution?
2. How many members are in the administrative body?
3. How are they elected to the administrative body?
4. What is the tenure of the elected body?
5. Is there a maximum limit to participate in the president or secretary election?
6. How do you deal with disputes?
7. What do you say about the allegations regarding funding/election or else?

Appendix-II

Interview Schedule for Medical Students

1. Name:.....

2. Age:..... 3. Sex: Male ☐ Female ☐

4. Religion: Christian ☐ Hindu ☐ Islam ☐ Others (specify):

5. Average family income (Annual).....

6. Social Category: SC ☐ ST☐ OBC☐ General ☐

7. Occupation of the parents: Government ☐ Private ☐ Business☐ Others (specify):

8. which is your residing location..... 9. District.....

10. Family land ownership (in cent).....

11. What assets do you have in college? Motorcycle ☐ Car ☐

12. Why did you prefer this medical institution?

13. How much is your course fee per annum?

14. Do you get any government scholarships? Yes☐ No☐

15. Do you get any other scholarships? Yes☐ No ☐

16. Have you availed of any education loans? Yes☐ No☐

17. From where, Bank☐ government agency☐ others (specify):

18. Do you believe in God? Yes ☐ No ☐

19. Are you religious? Yes☐ No☐

20. Do you attend religious functions? Yes☐ No☐

21. If Yes, where? Common prayer centres☐ Home☐

22. How frequently? Daily☐ Occasionally ☐ Once in every week☐

23. Do you believe in God-men/women? Yes☐ No☐

24. Do you believe that they have divine power? Yes ☐ No☐

25. If No, do you think they are doing business with spirituality? Yes☐ No☐

26. Do you believe that they can cure diseases? Yes☐ No☐

Appendix-III

Interview Schedule for Care Receivers

1. Name of the user or principal respondent:

2. Relationship with the user:

3. Age of the user:.....

4. Sex: Male ☐ Female ☐

5. Religion: Christian ☐ Hindu ☐ Islam ☐ Others (Specify)

6. Education:.....

7. Social Category: SC ☐ ST ☐ OBC ☐ General ☐

8. Where do you come from: .....

9. District.....

10. Location of residence: Municipality ☐ Panchayat ☐ Other ☐

11. How far it is from this hospital (in KM)

12. Land ownership (in cent)

13. Occupation:

14. Family Income:

15. What assets do you have? Motorcycle ☐ Car ☐ Others (specify)

16. Why did you select this hospital? Specialised ☐ Economical ☐ Other ☐ Specify

17. How many days have you been here?

18. Did you go to any other health care centre before coming here? Yes ☐ No ☐

19. If yes, which hospital (name).....

20. Reason for leaving that hospital: Fewer facilities ☐ Waiting ☐ Other (specify):

21. Why did you choose the hospital Near ☐ Economical ☐ Other ☐ Specify

22. Average cost of care that you availed here?.....

23. How do you pay the bill? Govt health insurance ☐ Private health insurance ☐ Other (specify):

24. Do you get any concessions here? Yes ☐ No ☐

25. If yes, how?

26. Did you face any inconvenience here? Yes☐ No☐

27. Do you believe in God? Yes☐ No☐

28. Are you religious? Yes☐ No☐

29. Do you attend religious functions? Yes☐ No☐

30. If Yes, where? Common prayer centres☐ home☐ Others (specify)

31. How frequently? Daily☐ Occasionally ☐ Once in every week☐

32. Do you believe in God-men/women? Yes☐ No☐

33. Do you believe that they have divine power? Yes ☐ No☐

34. If No, do you think that they are doing business with spirituality? Yes☐ No ☐

35. Do you believe that they can cure diseases? Yes☐ No☐

36. Your comments on

i) Services ii) Religious charity iii) Kerala's spiritual business

Appendix-IV

Interview Schedule for healthcare givers

1) Name
2) Religion
3) Caste
4) Qualification
5) How long have you been working in this hospital (in months)?
6) What transition happened here during your work period?
    a) In administration
    b) Infrastructure
    c) Fees
    d) Human resource
    e) Patient load and
    f) Others
7) What are the outreach activities in which the hospital engages?
8) What are the communities you have been providing outreach services?
9) Where are their geographical locations? (How far it is?)
10) What is the training provided to the caregivers?
11) How frequent is it?
12) How is the experience (charisma) of prominent doctors helpful in providing care?
13) How does the social identity of key administrators influence you?
14) What about your religious belief and practices?
    a) Frequency
    b) Occasions
    c) Place of worship
15) What do you think about the religious and political power of the foundations' leadership?
16) How does it help in the development of the institutions? What is your opinion?

Appendix-V

List of Institutions

Institution-A:- Mata Amritananta Mayi Foundation is a charity organisation, registered under Trust Act in 1988. It is an international charitable foundation located in the Kollam district of South Kerala. According to Home Affairs, the Ashram is the third-largest foundation receiving foreign funds during 2014-15 and consecutive years. It runs a 'highly sophisticated' medical college and tertiary care hospital in Kichi, Ernakulam district. A Hindu priest founded the organisation in 1981. She is an international spiritual leader and a self-acclaimed god-woman in Kerala. It works in the humanitarian field, including healthcare, disaster relief, environmental protection and education sector. It has been associated with 40 diverse organisations around the world.

Institution-B:- Gospel for Asia foundation focuses on poverty alleviation, literacy programmes and income-generating projects. It also runs a chain of schools, colleges and hospitals to provide educational and health services in Kerala. The foundation was registered under Trust Act-1882 in the year of 1993. Currently, it is not working in India due to the alleged fraudulent activities and legal suits filed in Kerala.

Believers Church Hospital is a healthcare project of the foundation located in Thiruvalla. A Metropolitan of the Church is the patron of the hospital. The hospital is on 25 acres in the Pathanamthitta district. The Church is dynamically involved in various nation-building social and educational projects, healthcare initiatives, charitable activities, community development programs, rehabilitation projects and relief work.

Institution-C:- Muslim Education Trust is registered under Societies Registration Act-1860 in Kozhikode district. The foundation has been running a medical college hospital, various health centres and hundreds of schools in India and abroad. The tertiary care hospital was started in 2003 in Perinthalmanna, Malappuram district. It includes medical college, teaching hospital, dental and nursing colleges. National and state statutory bodies have recognised it. Altogether 400 seats are available for MBBS, dental and nursing colleges.